Nursing and Midwifery Council
Fitness to Practise Committee

Substantive Hearing
Monday, 12 May 2025 – Tuesday, 27 May 2025
Resuming: Thursday, 20 November 2025 – Friday 28 November 2025
Resuming: Monday, 30 March 2026 – Thursday, 2 April 2026

Virtual Hearing

Name of Registrant:	**Carolyn Blore**
NMC PIN:	97I0379E
Part(s) of the register:	Registered Nurse - Adult nurse, Level 1 – 28 August 2000
Relevant Location:	Nottingham
Type of case:	Misconduct
Panel members:	Museji Ahmed Takolia (Chair, Lay member)
	Janet Fitzpatrick (Registrant member) (July and November 2025)
	Rachel Carter (Registrant member) (30 March – 2 April 2026)
	Sam Wade (Lay member)
Legal Assessor:	Charles Conway (12 - 27 May 2025)
	Charles Parsley (20 - 28 November 2025)
	Breige Gilmore (30 March 2026 - 2 April 2026)
Hearings Coordinator:	Yousrra Hassan
Nursing and Midwifery Council:	Represented by Tom Hoskins, Case Presenter
Carolyn Blore:	Not Present and unrepresented

Facts proved:	1b(i), 1c, 1d(i), 1d(ii), 2a(i), 2b(i), 2b(iii), 2b(iv), 2b(vii), 3b, 4a, 4b, 4c, 4d(i), 4d(ii), 4f, 4i, 4k, 4l, 5a(i), 5a(ii), 6a, 6b, 6c, 6d, 8a, 8b, 9, 10c
Facts not proved:	1a (i), 1a (ii), 1a(iii) 1a(iv), 1a(vi), 1a(vii), 1b(ii), 1b(iii), 1b(iv), 2a(ii), 2b(ii), 2b(vi), 2b(v), 3a, 4e, 4g, 4h, 4j, 5a(iii), 7, 8c, 10a, 10b, 11a, 11b
Fitness to practise:	Impaired
Sanction:	**Striking-off order**
Interim order:	**Suspension Order (18 months)**

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Blore was not in attendance and that the Notice of Hearing letter had been sent to Ms Blore's registered email address by secure email on 10 April 2025.

Mr Hoskins, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Blore's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Blore has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

Decision and reasons on proceeding in the absence of Ms Blore

The panel next considered whether it should proceed in the absence of Ms Blore. It had regard to Rule 21 and heard the submissions of Mr Hoskins who invited the panel to continue in the absence of Ms Blore. He submitted that Ms Blore had voluntarily absented herself and had waived her right to attend.

Mr Hoskins referred the panel to the documentation from Ms Blore which included the email correspondence between the case officer and Ms Blore in which she states that she is content for the hearing to proceed in her absence due to her ongoing health conditions. He also noted on previous occasions when the matter was listed,

Ms Blore had indicated that she had consented for those and for future hearings to proceed in her absence.

Ms Blore is not in attendance due to her ongoing health condition. However, the matter has previously been listed on two occasions, and Ms Blore has provided her consent by email dated 06 May 2025:

> *"I am unable to attend the meeting but give consent for the panel to proceed in my absence"*.

The panel deliberated on the developing nature of her illness and was insufficiently assured on details about it. The charges are serious, as is the potential outcome for her and therefore it decided to adjourn proceedings in order for further enquiries to be made.

Following the short adjournment, the panel was advised by the case officer that further information was available about Ms Blore's health and her reasons for non-attendance in an email which had not previously been provided to the panel. The email included the following:

> *"Please proceed with future hearings without me attending. [PRIVATE].*
>
> *…[PRIVATE]"*

The panel accepted the advice of the legal assessor.

The panel noted that its discretionary power to proceed in the absence of a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised *'with the utmost care and caution'*.

The panel decided to proceed in the absence of Ms Blore. In reaching this decision, the panel considered the submissions of Mr Hoskins, and the advice of the legal assessor. It noted that:

- Ms Blore has informed the NMC that she has received the Notice of Hearing and confirmed twice by email she is content for the hearing to proceed in her absence;
- There is no reason to suppose that adjourning would secure her attendance at some future date;
- The charges relate to events that occurred in 2022. Further delay may have an adverse effect on the ability of witnesses accurately to recall events;
- A witness has been warned for today to give live evidence, others are due to attend later on in the week;
- Not proceeding may inconvenience the witnesses, their employer(s) and, for those involved in clinical practice, the clients who need their professional services;
- There is a strong public interest in the expeditious disposal of the case.

The panel acknowledged that there is some disadvantage to Ms Blore in proceeding in her absence. The evidence upon which the NMC relies on will have been sent to her at her registered email address. It also acknowledged that Ms Blore will not be able to challenge the evidence if she does not attend nor will she be able to give live evidence. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Blore's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented.

In these circumstances, the panel decided that it is fair to proceed in the absence of Ms Blore. The panel will draw no adverse inference from Ms Blore's absence in its findings of fact.

Details of charges

That you, a registered nurse whilst working as the registered manager of the Ashford Care Home ('the Home'):

Safety

1) Failed to ensure the Residents' physical, social, privacy, dignity and/or psychological needs in that:

   a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:

      i. Resident 1
      ii. Resident 2
      iii. Resident 3
      iv. Resident 4
      v. Resident 5
      vi. Resident 6
      vii. Resident 7

   b) On 18/19 January 2022, failed to ensure care plans and/or risk assessments were produced in line with the care plan policy or at all in respect of the following residents:

      i. Resident 2
      ii. Resident 4
      iii. Resident 5
      iv. Resident 7

   c) In respect of Resident 7, a handover document dated 15 January 2022 inaccurately recorded them as having dementia and/or behavioural issues.

d) In respect of Resident 8 and Resident 9:

   i. a capacity assessment was not undertaken for their consent to sharing a room
   ii. there was no record that their right to privacy had been considered

2) Failed to ensure a safe and/or comfortable environment for residents in that:

   a) In respect of Resident 8 and 9:

      i. a capacity assessment was not undertaken for their consent to sharing a room
      ii. a shared room did not afford them privacy and/or dignity when undergoing continence care.

   b) The Home was below the expected standard in that:

      i. it required redecoration and/or building work
      ii. it was cluttered
      iii. the wheelchair lift was not stored in the neutral position
      iv. In respect of Residents 10 and 11, there were baby/security gates outside their room creating a risk of falls
      v. there was insufficient signage for residents with a diagnosis of dementia
      vi. you failed to accept professional advice in respect of matters charged in 3)b)i) – v)
      vii. you failed to accept professional advice to ensure that the service was safe and/or challenge the provider in not creating an action plan to respond to the Fire Risk Assessment Report 2021.

3) Placed restrictions on residents without adequate assessments in that:

   a) In respect of Resident 1, there was no assessment to consider alternatives to bed rails

b) In respect of Residents 10 and 11, restricted their freedom of movement by placing baby/security gates on their bedroom doors, without a capacity and/or best interest assessment.

4) On 18/19 January 2022, during the CQC inspection, failed to implement and/or promote infection control measures in response to the Covid 19 pandemic in that:

a) There was no social distancing by staff in the staff room/activities room

b) There was no wearing of face masks by staff in the staff room/activities room

c) You wore a fabric mask instead of a fluid mask as directed by the Government

d) You demonstrated poor PPE practice when responding to an incident with Resident 1 in that:

i. you failed to wear a fluid mask and/or
ii. you failed to ensure a member of staff involved in the incident wore a fluid face mask.

e) You failed to ensure measures were in place to identify if a resident had contracted Covid 19.

f) You failed to follow the 'bare elbow guidance' in that you wore a long-sleeved T-shirt under your uniform.

g) There were empty PPE stations in the Home

h) Fluid repellent masks were only available at the entrance to the Home.

i) Waste was not disposed of within infectious material bags in contravention of Government guidance on disposal of infectious materials.

j) The cluttered state of the Home inhibited effective cleaning

k) There was no record of the vaccination status of those visiting the Home

l) The Home's Infection Prevention and Control Policy was inadequate in that there was no guidance on cleaning, admissions and/or Covid 19 prevention.

5) On 19 January 2022, failed to keep accurate and/or up to date recruitment records in that:

a) 2 recruitment files did not contain:
   i. Second references
   ii. Full employment history
   iii. DBS checks

6) On 19 January 2022, you failed to demonstrate that staff had sufficient training in one or more of the following areas:

a) Infection control and prevention
b) safeguarding adults
c) pressure area care
d) specific needs

7) Failed to supervise the competency of staff to provide safe care and/or treatment in that formal supervision was only completed once a year.

8) Failed to safeguard residents from harm and/or neglect in that:

a) In respect of Resident 4, following an incident on 29 December 2021, you failed to investigate and/or refer to safeguarding

b) In respect of Resident 13, following incidents on or around 13/14 April 2021 and/or 16 April 2021, you failed to investigate and/or refer to safeguarding.

c) In respect of Resident 14, following an incident on 29 December 2021, you failed to investigate and/or refer to safeguarding.

Medication

9) In respect of Resident 8, there was no guidance in their care plan about when and/or why they should be given their prescribed medication (PRN Haloperidol).

Documentation

10) Failed to keep clear and accurate resident records in that:

a) On 18/19 January 2022, you failed to ensure there was in place and/or failed to make available, a Covid 19 plan, falls risk assessment, malnutrition chart, waterlow assessment and/or moving and handling assessment in respect of the following residents:

i) Resident 1
ii) Resident 3
iii) Resident 5
iv) Resident 6
v) Resident 7

b) On 18/19 January 2022, in respect of Resident 8, failed to ensure there was a behaviour chart in place.

c) In respect of Resident 12, failed to ensure that their care plan was updated to reflect the recommendation for a level 4 pureed diet from July 2021.

11) On 15 January 2022, recorded/or allowed to be recorded one or more of the following comments which were derogatory and/or inappropriate:

a) ‘Kleptomaniac’ to describe Resident 11.

b) ‘Sexual deviant’ and ‘rude’ to describe Resident 2.

AND in light of the above, your fitness to practise is impaired by reason of your misconduct.

Decision and reasons on application for hearing to be held in private

Mr Hoskins made an application that this case be held in private on the basis that proper exploration of Ms Blore’s case involves details about her health conditions being disclosed. The application was made pursuant to Rule 19 of the ‘Nursing and Midwifery Council (Fitness to Practise) Rules 2004’, as amended (the Rules).

Mr Hoskins submitted that part of the hearing to be held in private to protect Ms Blore’s health-related information. Reference was made in earlier correspondence, which outlines Ms Blore’s health condition and her voluntary absence from the hearing. In this email Ms Blore indicated that she is currently [PRIVATE] and prefers to focus on her health, she has given consent for the panel to proceed in her absence.

The legal assessor reminded the panel that while Rule 19(1) provides, as a starting point, that hearings shall be conducted in public, Rule 19(3) states that the panel may hold hearings partly or wholly in private if it is satisfied that this is justified by the interests of any party or by the public interest.

The panel decided in all of the circumstances it would hear parts of the hearing in private, when Ms Blore’s health was discussed.

The panel agreed that any matters relating to Ms Blore’s health should be heard in private to protect her confidentiality.

Consideration of whether to admit hearsay evidence

The panel considered whether or not to admit into evidence the following documents contained in Ms Blore’s hearsay bundle:

- A letter dated 14 March 2022 was sent to the CQC by Colleague 1's solicitor making representations in relation to the CQC findings.

- A letter to the CQC dated 6 June 2022, signed by Colleague 1 disputing the findings of the CQC investigations.

The panel concluded having regard to DMA-6 of the NMC guidance that both these letters were hearsay because Colleague 1 was not being called to give evidence.

Mr Hoskins accepted that this evidence is relevant but submitted that it would be unfair to the NMC to admit this evidence because he would have no opportunity to test it by cross examining Colleague 1.

He referred to the legal framework, including Rule 31 and the case of Thorneycroft v NMC [2014] EWHC 1565 (Admin), which require hearsay evidence to be demonstrably reliable or capable of being tested. Since Colleague 1 was not available to give evidence or be cross-examined, Mr Hoskins argued that their claims could not be reliably assessed.

The panel considered whether Ms Blore would be disadvantaged by the change in the NMC's position, that is to say moving from reliance upon the live evidence of Colleague 1 and/or his solicitor to allowing the hearsay evidence to be adduced.

After careful deliberation the panel decided that it would be fair and relevant to adduce the evidence of Colleague 1 and his solicitor. It further acknowledges that the charges are serious and could have very significant consequences for Ms Blore's career. In these circumstances it determined that it is fair for this evidence to be admitted. The panel considered that some elements of the hearsay could be tested through the live evidence of other witnesses, and the NMC would have an opportunity to challenge aspects of the hearsay during the hearing.

The panel had regard to the guidance set out in *Thorneycroft* and decided that the evidence was not the sole or decisive evidence in relation to the charges and there was no suggestion that the evidence of Colleague 1 or his solicitor was fabricated.

In all the circumstances the panel determined that it would be relevant and fair to admit Colleague 1 and his solicitor's evidence as hearsay. The panel concluded that the weight it would attach to the hearsay evidence would be decided when it has heard all the evidence in the case.

Background

[PRIVATE] ("the Home") is one of the smallest facilities in the [PRIVATE] area, with a total capacity of 20 residents. The concerns raised in this case are based primarily on evidence obtained by the Care Quality Commission (CQC). The CQC's lead inspector is a key witness in these proceedings, Witness 1.

In addition to the CQC, the panel heard from a senior manager, Witness 2 from the local Clinical Commissioning Group (which subsequently became part of the Integrated Care Board), and who became involved, because of her oversight of responsibilities for care homes.

Ms Blore has served as the Registered Manager of the Home, which is a statutory role with the CQC, for nearly a decade. She has also been a Registered Nurse and Clinical Lead at the Home. The regulatory concerns that triggered these proceedings stem from a CQC inspection carried out during 18 - 19 January 2022, with the inspection report published on 17 March 2022. At the time of the inspection by the CQC, the Home was operating at only 50% occupancy.

It is well-known and widely reported fact that the COVID-19 pandemic had a profound impact on care institutions across the country, significantly disrupting operations. Whilst the panel recognised the challenges posed by the pandemic, the CQC was still responsible for assessing whether Ms Blore had fulfilled her responsibilities as the Home's manager and Registered Nurse.

At the time of the CQC inspection, the Home's reliance on agency staff could have contributed to operational instability and increased risks. The Home also followed a practice of allowing new residents to settle in before undertaking full clinical assessments; a method that, while perhaps well-intentioned, raised concerns regarding its alignment with standards of nursing practice. This set of circumstances combined with, alleged poor communication between the Home and key partner organisations, such as hospitals and social services, appears to have exacerbated matters significantly. Many of the difficulties experienced within the Home appeared to stem from inadequate handovers by referral agencies and a lack of external support during the referral and admission of new residents.

Furthermore, the CQC inspection revealed that seven emergency admissions had occurred shortly before their visit, with residents staying at least 12 days. Ordinarily this would require full assessments to be undertaken within one week of admission. The assessments in these specific cases had not been completed. The panel is tasked with determining whether these shortcomings amount to a serious breach of Ms Blore's duties as both a manager and nurse, and whether the challenges posed by the COVID-19 pandemic offer any reasonable justification for these failings.

Decision on admission of additional documents

During the fact-finding stage, the panel raised concerns about missing appendices referenced in the letter from Colleague 1's solicitor, which related to representations made by the Home to the CQC. The panel considered these documents potentially important to ensuring a fair and balanced decision. As such, it agreed that steps should be taken to obtain the missing materials.

The panel recognised that due to Ms Blore's previously stated health and personal challenges, a timely response may not be possible. Therefore, it proposed a three-step approach: first, contacting the registrant; second, if there was no response, reaching out to Colleague 1's solicitor to explain the relevance of the documents and request their disclosure; and third, as a last resort, contacting the CQC directly. The panel intended to send out the request promptly and would reconvene once a timeline was established to determine whether an adjournment would be necessary.

In response, Mr Hoskins acknowledged the panel's concerns about the missing appendices, specifically those referred to in Ms Blores bundle and the hearsay bundle, including Appendices 16 through 22. Mr Hoskins confirmed that the NMC held the same documents as the panel and had no additional material. He noted that Ms Blore herself submitted these documents and had made a deliberate decision about what to include. The only excluded document was a confusing and unhelpful response to a case management form.

Mr Hoskins submitted that the NMC had fulfilled its disclosure obligations and had taken all reasonable steps to support the Ms Blore's case. Any documents not included were considered third-party materials beyond the NMC's control. While the panel could request these materials under the authority of *The Professional Standards Authority v (1) The Nursing and Midwifery Council (2) Jozi [2015] EWHC 764 (Admin)*, Mr Hoskins warned the panel that doing so would likely cause significant delays and prevent the panel from concluding the fact-finding stage within the current hearing window.

The panel accepted the advice of the legal assessor.

Following the receipt of the additional appendices that were requested by the panel, it then went onto consider whether to admit them into evidence. Mr Hoskins raised objections to the inclusion of certain records, particularly those that pre-date the inspection or relate to patient care records not authored by Ms Blore. He cited Rule 31 and asked that these documents be excluded, stating that some patient records were outside the relevant period or not authored by Ms Blore, and therefore lacked probative value.

The panel however decided to admit them as Exhibit 8 in their entirety. It determined that it would be fair and relevant to admit the documents and believed these could assist the panel in achieving a balanced understanding of the case. It emphasised that it is a professional panel capable of discerning the weight and provenance of the evidence presented.

With reference to the hearsay nature of some evidence in the bundle of documents submitted by Ms Blore, the panel acknowledged this but chose not to exclude it, stating that it would handle such material with appropriate caution.

Ultimately, the panel concluded that the fairness to Ms Blore outweighed any prejudice to the NMC, especially as the documents may support Ms Blore's case, taking account of Ms Blore's absence from this hearing and the fact that she is unrepresented. It confirmed that it considered this approach to be balanced and fair in circumstances and, it would assess the evidence critically and carefully during deliberations, remaining alert to issues of provenance and relevance.

Decision and reasons on facts

In reaching its decisions on the disputed facts, the panel took into account all the oral and documentary evidence in this case together with the submissions made by Mr Hoskins.

The panel has drawn no adverse inference from the non-attendance of Ms Blore.

The panel was aware that the burden of proof rests on the NMC, and that the standard of proof is the civil standard, namely the balance of probabilities. This means that a fact will be proved if a panel is satisfied that it is more likely than not that the incident occurred as alleged.

The panel heard live evidence from the following witnesses called on behalf of the NMC:

- Witness 1: Interim Inspection Manager for the CQC

- Witness 2: Clinical Quality Manager for the Integrated care Board team and Registered Nurse.

The panel faced a particular challenge with the treatment of evidence that formed part of Exhibit 8, that is to say that the appendices attached to the letter from Colleague 1's solicitor. This was provided by Colleague 1 after Witness 1 gave her oral evidence. It is not clear to the panel whether she has seen this material before providing her witness statement or before giving her oral evidence. The panel considers the appendices provided by Mr Hoskins, to contain important and relevant information including, risk assessments for multiple residents that Witness 1 stated that she did not see at the time of the inspection.

During her oral evidence the panel questioned Witness 1 about her approach to reviewing documentation during her inspection, in particular the absence of documents. Witness 1 explained that her findings were based on the documents that were presented to her, and she did not request or attempt to locate any specific documents beyond those that were provided.

In light of this, the panel is satisfied that Witness 1 appears not to have been shown or had access to the aforementioned appendices that form part of appendices provided by Mr Hoskins. Despite this, it is the panels view that the appendices in its entirety contains credible and relevant evidence that in some cases may support Ms Blore's position, and therefore it should form part of the evidence adduced in this case.

Before making any findings on the facts, the panel heard and accepted the advice of the legal assessor.

The panel then considered each of the disputed charges and made the following findings.

'That you, a Registered Nurse whilst working as the registered manager of [PRIVATE] ('the Home'):

<u>Safety</u>

Charge 1(a)(i)

‘Failed to ensure the Residents’ physical, social, privacy, dignity and/or psychological needs in that:

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
    i) Resident 1

This charge is found NOT proved.

The panel considered whether in the case of each individual resident referred to in the charges, between 16 December 2021 and 9 January 2022, Ms Blore had failed to ensure their physical, social, privacy, dignity and/or psychological needs were met by admitting the resident without an admission assessment and/or support needs information.

The panel noted that where a charge alleges a failure by Ms Blore to act in a particular manner, it implies that she was subject to a duty or obligation in relation to that particular action which she is alleged not to have discharged. Further, the panel considered that where the duty or obligation alleged to have been breached is one of ensuring an outcome, that obligation is correspondingly more rigorous in that the scope for non-compliance is limited.

In seeking to identify the duties and responsibilities to which Ms Blore was subject to, the panel firstly had regard to the NMC Code, of *‘Prioritise people’* which states that:

> *“You make their care and safety your main concern and make sure their dignity is preserved, and their needs are recognised, assessed and responded to.”*

Secondly, the panel took into account wording in the job description of the Home Manager which under the heading of *‘Resident Care’* states that one of her principal responsibilities is:

“To ensure that the emotional, spiritual, physical, medical and material needs of the residents are recognised, assessed and met.”

Taken together, the panel is satisfied that the omissions alleged in the charge fall within the scope of the above duties and responsibilities.

The panel reviewed multiple pieces of evidence, including a bed rail risk assessment dated 8 January 2022. This is within the timeframe of the charge. This assessment, along with other supporting documents such as pressure sore, mobility, and continence assessments, suggested that some level of admission and support needs assessments had been conducted for Resident 1.

The panel noted that it had not seen the original source documents from which was Resident 1’s records. However, it found that its contents were coherent, consistent, and aligned with the information which included the social services assessment, hospital discharge information, and the bed rail assessment.

In order for it to be found proved, the panel noted that the sub-charge requires that there should have been:

“no evidence of admission assessment and or support needs information”.

However, it noted the evidence provided by Witness 1 and acknowledged the presence of some assessment information in the Resident’s records.

In taking account of the evidence provided by Ms Blore, which is titled, ‘*Note from CB/extracts from risk assessment and care plan SU1’.*

The panel noted that the actual entry is quite detailed and includes information such as Waterlow score, use of bed rails, skin integrity, mobility, continence and confusion.

The panel also took into account Ms Blore's credibility and considered her to be a person of good character and found no indication or motives to suggest that she had fabricated information about residents in the care of the Home.

On the balance of probabilities, the panel therefore concluded that there was evidence of at least some initial admission assessment and support needs documentation for Resident 1 and therefore found this charge not proved.

Charge 1(a)(ii)

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
    ii) Resident 2

This charge is found NOT proved.

In moving forward to consider the remaining sub-charges relating to other residents, the panel relied on the same analysis and reasoning as it applied in its consideration of the allegations relating to Resident 1.

The panel considered whether there was sufficient evidence to support the allegation that Ms Blore had failed to ensure an admission assessment and/or support needs information for Resident 2. In reviewing Resident 2's patient records, the panel noted that Witness 1 in her evidence, acknowledged that although the information was limited, it was not entirely absent.

The panel considered the presence of a discharge form containing care details, as well as Ms Blore's supporting evidence. Witness 1's statement referred to the daily notes and a local authority assessment which were not generated by the Home but were provided by social services. The panel was shown these (daily) notes, which on closer examination confirmed that although the information within them was limited in scope, it did include important clinical information from an external body.

Furthermore, the panel noted that in evidence, an admission note specifically recorded on the date of Resident 2's entry into the Home. It found corroborative evidence in the Activities of Daily Living (ADL) column, where documentation (screenshot of the computer folder containing the individual parts of the care plan) corresponded to the information shown on the daily care notes for the ADLs for Resident 2.

Taking all of this into account, the panel concluded that while documentation may not have been extensive, there was sufficient and corroborative evidence to suggest an assessment and support the fact that a care planning process had started with Resident 2. This charge is therefore found not proved.

Charge 1(a)(iii)

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
   iii) Resident 3

This charge is found NOT proved.

The panel first considered the evidence of Witness 1 who confirmed that Resident 3 was admitted to the Home on the 9 January 2022 the last day of the period referred to in the charge, (16 December 2021 – 9 January 2022). Witness 1 stated at the time of the inspection (18 - 19 January 2022) that she did not see any care plans or risk assessment for Resident 3.

Witness 1 in her oral evidence was questioned as to why she hadn't provided anything in relation to Resident 3 in her evidence. She responded that she was confident that she had not seen any documentation in relation to this resident, noting that she would have taken a photograph of it if she had.

Ms Blore's response, was also examined closely. The panel noted that it contained information in relation to Resident 3's needs and the assessments that had been

carried out. Although this document did not contain any specific dates it was able to establish the relevant dates in other documents provided to it.

The panel next considered documentation provided by Colleague 1. This included a nutrition risk score, personal handling risk assessment and plan, and a falls risk assessment. Significantly, these documents include entries on 9 January 2022, which the panel noted is the last day of the charging period.

Given the presence of contemporaneous evidence showing that Resident 3's support needs were assessed within the time frame of the charge, the panel find this charge not proved.

Charge 1(a)(iv)

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
   iv) Resident 4

This charge is found NOT proved.

In reviewing the evidence relating to Resident 4, the panel considered several sources of evidence, including Witness 1's statement and Resident 4's patient records. It shows that some form of assessment was conducted within the relevant time frame. Specifically, a discharge summary dated 16 December 2022 was available and referred to key clinical indicators such as the Waterlow score and nutritional risk, indicating that an initial assessment of needs had taken place within the charging window.

The panel also took into account the evidence provided during cross-examination of Witness 1, as well as Ms Blore's own response in her statement.

Given the presence of contemporaneous assessment documentation and in light of the panel's reasoning in the similar cases of Residents 1 and 2, it concluded that

there were sufficient, credible evidence of an initial admission assessment and support needs planning for Resident 4. This charge is therefore found not proved.

Charge 1(a)(v)

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
   v) Resident 5

This charge is found NOT proved.

In considering the evidence relating to Resident 5, the panel noted that the resident was admitted on 7 January 2022. Witness 1's statement highlighted concerns about the lack of care plans or risk assessments.

Ms Blore's response, found in Resident 5's patient records, was also examined closely. The panel noted that it contained extensive information in relation to Resident 5's needs and the assessments that had been carried out. Although this document did not contain any specific dates it was able to establish the relevant dates in other documents provided to it.

The panel next considered documentation provided by Colleague 1. This included an initial assessment, nutrition risk score, personal handling risk assessment and a Waterlow score. Significantly, these documents include entries on the 7 January 2022, which the panel noted is within the charging period.

Given the presence of contemporaneous and supported evidence showing Resident 5's support needs were assessed within the charging period, the panel found this charge not proved.

Charge 1(a)(vi)

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
    vi) Resident 6

This charge is found NOT proved.

In assessing the evidence for Resident 6, the panel considered several documents, including the safeguarding referral and Ms Blore's response. Witness 1's written evidence was also reviewed.

The panel focused particularly on the handover document and the supporting material, which appeared to show a snapshot of different documents comprising elements of a care plan. The panel noted that the modification dates of the electronic documents (which the panel took to mean the date when the document was last updated) on most of these records were dated 23 December 2021, that is to say within the timeframe specified in the charge.

Taking this into account, the panel concluded that the documents did provide some evidence of an assessment being carried out during the charging period. As a result, it found that there was sufficient supporting and corroborative evidence to conclude that Ms Blore did not fail to complete an initial assessment or support needs plan for Resident 6. This charge was therefore found not proved.

Charge 1(a)(vii)

a) Between 16 December 2021 and 9 January 2022, one or more of the following residents were admitted with no evidence of admission assessment and/or support needs information:
    vii) Resident 7

This charge is found NOT proved.

In considering the evidence for Resident 7, the panel reviewed Witness 1's statement, where she referenced the date of admission for Resident 7 as 9 January 2022.

The panel reviewed the evidence bundle provided by Colleague 1 and found an initial assessment review, a body map and a personal handling plan all dated 9 January 2022 in relation to Resident 7.

The panel also examined Ms Blore's response in Resident 7's patient records, which offered a summary of the situation. Despite the lack of comprehensive care plans, there was some documentation available in relation to initial assessments that had been taken on behalf of Resident 7.

Given the presence of contemporaneous and supported evidence showing that Resident 7's support needs were assessed within the charging period, the panel found this charge not proved.

Charge (1b)(i)

b) 'On 18/19 January 2022, failed to ensure care plans and/or risk assessments were produced in line with the care plan policy or at all in respect of the following residents:
   i) Resident 2'

This charge is found proved.

In relation to this charge, the panel first considered the excerpt from the care plan policy. The panel noted that the policy states:

> *"After shadowing the resident for a week we will complete a moving and handling assessment, falls risk assessment, a pressure sore assessment and a personal risk assessment."*

Given the above the panel decided that Ms Blore, as the Registered Manager, had a duty to ensure care plans and/or risk assessments were produced within a week of a resident's admission to the Home.

The panel noted that Resident 2 was admitted to the Home 6 January 2022 and accordingly a care plan assessment should have been produced by the 13 January 2022.

The panel heard from Witness 1, who clarified the CQC's regulatory function in scrutinising the delivery of fundamental nursing care in line with professional standards under the Health and Social Care Act 2008. Specifically, paragraph 32 of the Act was cited to reinforce the expectation that nurses must maintain core elements of care delivery, including proper care planning.

In her response, Ms Blore submitted that it was the Home's practice to conduct a full risk assessment once a resident had settled. This process included assessments for falls, mobility, pressure area care (Waterlow score), pain management, and ensuring a safe environment.

The panel also considered the evidence in relation to Resident 2 provided by Colleague 1 and noted that it contained an eating, drinking and nutrition care plan, an elimination care plan, a personal care plan, body temperature plan, mobility, moving and handling care plan, a skin medication and pain care plan, a sexual, social and emotional care plan, a sleeping care plan and a death and dying care plan. All of these documents are dated either 27 or 28 January 2022; dates falling outside the requirements of the care plan policy.

Having considered the totality of the evidence before it the panel determines that there is no evidence that Ms Blore ensured that care plans and all risk assessments were produced in line with the care plan policy. In the case of Resident 2 the entries that the panel has found fall outside of the period required under the care plan policy. The panel therefore found this charge proved.

Charge (1b)(ii)

b) 'On 18/19 January 2022, failed to ensure care plans and/or risk assessments were produced in line with the care plan policy or at all in respect of the following residents:'

ii) Resident 4'

This charge is found NOT proved.

The panel considered the evidence provided in relation to Resident 4. It considered Witness 1's written statement which stated that there were no care plans or risk assessments in Resident 4's records at the time of her inspection.

Resident 4 was admitted to the Home on 29 December 2021. The panel considered the evidence provided in relation to Resident 4.

The panel noted that the documents before it met the requirements set out in the care planning policy and demonstrated that key risk assessments were completed. It found that care plans and risk assessments had been produced in accordance with the care planning policy prior to the CQC inspection on 18 – 19 January 2022. They were dated 29 December 2021, which is the date of admission, and therefore complies with the Home's policy to do this within one week of admission.

Given the availability of these records during the CQC inspection and their relevance to care planning, the panel concluded that there was sufficient evidence of compliance. The panel therefore found this charge not proved.

Charge (1b)(iii)

b) 'On 18/19 January 2022, failed to ensure care plans and/or risk assessments were produced in line with the care plan policy or at all in respect of the following residents:

iii) Resident 5'

This charge is found NOT proved.

The panel considered the evidence provided in relation to Resident 5. It considered Witness 1's written statement which stated that there were no care plans or risk assessments in Resident 5's records at the time of her inspection.

Resident 5 was admitted to the Home on 7 January 2022.

The panel noted that the documents before it met the requirements set out in the care planning policy and demonstrated that key risk assessments were completed. It found that risk assessments had been produced in accordance with the care planning policy prior to the CQC inspection on 18 – 19 January 2022. The panel determined that the Nutrition Risk Score and a Falls Risk Assessment, both dated 7 January 2022, which is the date of admission, comply with the Home's policy to do this within one week of admission.

Given the availability of these records during the CQC inspection and their relevance to care planning, the panel concluded that there was sufficient evidence of compliance. The panel therefore found this charge not proved.

Charge (1b)(iv)

b) 'On 18/19 January 2022, failed to ensure care plans and/or risk assessments were produced in line with the care plan policy or at all in respect of the following residents:

iv) Resident 7'

This charge is found NOT proved.

The panel considered the evidence provided in relation to Resident 7. It considered Witness 1's written statement which stated that there were no care plans or risk assessments in Resident 7's records at the time of her inspection.

Resident 7 was admitted to the Home on 9 January 2022.

The panel noted that the documents before it met the requirements set out in the care planning policy and demonstrated that key risk assessments were completed. It found that risk assessments had been produced in accordance with the care planning policy prior to the CQC inspection on 18 – 19 January 2022. The panel determined that the Initial Assessment was completed on 9 January 2022 and the Nutrition Risk score and a Waterlow Assessment were completed on the 10 January 2022.

Given the availability of these records during the CQC inspection and their relevance to care planning, the panel concluded that there was sufficient evidence of compliance. The panel therefore found this charge not proved.

Charge 1(c)

> ‘In respect of Resident 7, a handover document dated 15 January 2022 inaccurately recorded them as having dementia and/or behavioural issues.’

This charge is found proved.

In this charge, the panel considered the handover document dated 15 January 2022, which had recorded Resident 7 as having dementia and/or behavioural issues. Witness 1's statement clarified that the resident had conditions such as Crohn’s disease but did not have a dementia diagnosis. Whilst it was also suggested in Resident 7’s personal details form (produced by the Home) that dementia was *"undiagnosed”*, the panel did not have any evidence to support this statement as being accurate.

The panel was provided with information that was in the form of a hospital assessment dated 16 December setting out the conditions from which the resident was suffering, but which does not contain any reference to dementia.

As there was no credible or corroborative evidence to support the claim that Resident 7 had dementia, the panel determines that the handover document dated

15 January 2022 inaccurately recorded Resident 7 as having dementia and therefore found this charge proved.

Charge 1(d)(i)

‘In respect of Resident 8 and Resident 9:

(i) a capacity assessment was not undertaken for their consent to sharing a room’

This charge is found proved.

The panel considered the evidence in relation to whether a capacity assessment was undertaken for Residents 8 and 9 before they were placed in a shared room. Witness 1’s statement was that the residents ended up sharing a room without clear documentation of consent or assessment of their capacity to consent.

The panel also noted Ms Blore’s account, in which she acknowledged the shared room arrangement for these residents, occurred during the COVID-19 period as part of efforts to maintain safe care.

However, the panel did not find any reliable evidence confirming that a capacity assessment had been undertaken for either resident in relation to the room-sharing arrangement. The panel noted this charge is directed as to whether an assessment undertaken to assess the resident’s consent. Ms Blore would appear to be mistaken in identifying the primary consideration as one of safety.

Given the absence of capacity assessments and the implications this had for respecting the residents' dignity, particularly during a period where sensitivity towards residents' rights was essential, the panel determined that this failure constituted a breach under the terms of Charge 1 and therefore this charge is found proved.

Charge 1(d)(ii)

'In respect of Resident 8 and Resident 9:

(ii) there was no record that their right to privacy had been considered'

This charge is found proved.

The panel considered whether the right to privacy for Residents 8 and 9 had been appropriately considered when they were placed in a shared bedroom. Both residents required support with continence care, an intimate form of care which raised significant concerns regarding the protection of their dignity and privacy in such a setting.

Documentation provided to the panel included a handover sheet that described Resident 8 as agitated, with behaviours such as biting, kicking, shouting, and swearing. Despite these concerns, there was no evidence that a capacity assessment had been undertaken to determine whether either resident could consent to sharing a room. Additionally, there was no indication in either care plan that their privacy needs had been evaluated or that guidance had been provided to staff on how to maintain dignity during personal care.

Ms Blore stated that a curtain divider had been in place for at least 16 years and had not previously been raised as a concern during inspections. Witness 1 highlighted that several rooms were small and not suitable for maintaining adequate privacy. Witness 1 further observed that residents were not always receiving person-centred care due to the room arrangements.

Witness 2, in her witness statement, emphasised that mental capacity assessments must be completed whenever room sharing is to take place within the Home. She explained that these assessments are legally required under the Mental Capacity Act 2005. The panel also referred to principles from the Mental Health Act 2005, particularly principles 1 and 4, concluding that there was no evidence the Home had

carried out any assessment to determine whether the shared accommodation was in the best interests of either resident.

Based on the totality of the evidence before the panel, it concluded that Ms Blore had failed to ensure the residents' right to privacy was properly considered and therefore found this charge proved.

Charge 2(a)(i)

'Failed to ensure a safe and/or comfortable environment for residents in that:

a) In respect of Resident 8 and 9:

    i) a capacity assessment was not undertaken for their consent to sharing a room'

This charge is found proved.

The panel first considered Ms Blore's job description which states that as the Registered Manager she was required to:

> *"ensure that the emotional, spiritual, physical, medical and material needs of the Resident are recognised, assessed and met"*.

The panel therefore concluded that Ms Blore had a duty to ensure a safe a comfortable environment for the residents.

Ms Blore's explanation was that the practice of using shared rooms divided by a curtain mirrored hospital arrangements and had been in place for 16 years without previous regulatory concern. However, the panel determined that this rationale did not constitute appropriate consent by the residents, nor did it replace the legal and professional obligation to assess residents' capacity in such intimate and potentially distressing circumstances.

For similar reasons to those set out in Charge 1d (i) the panel found no evidence that a capacity assessment was carried out in relation to their consent to sharing a room, it therefore concluded that Ms Blore failed to ensure a safe or comfortable environment in respect of Resident 8 and 9 and therefore found this charge proved.

Charge 2(a)(ii)

'Failed to ensure a safe and/or comfortable environment for residents in that:

a) In respect of Resident 8 and 9:

   ii) a shared room did not afford them privacy and/or dignity when undergoing continence care.'

This charge is found NOT proved.

This charge arises out of concerns relating to the CQC inspection relating to the close proximity of two residents' beds and its concerns about the lack of dignity and privacy for the residents.

Witness 1 states in her witness statement that:

> *"Continence support is a very intimate type of care and It is difficult to maintain a resident's right to privacy when receiving continence care in a shared room".*

The panel next considered Ms Blore's explanation of the situation, in which she said:

> "*This is exactly what is used in hospital, and we have had the same situation for at least 16 years. We have had numerous inspections in that time without issue being raised."*

Whilst the panel took into account Witness 1's view that regulatory standards have evolved over time, the panel preferred Ms Blore's explanation that curtains are

routinely used in healthcare settings to ensure that patients' privacy and dignity is maintained.

The panel therefore did not conclude that Ms Blore failed to ensure a safe and/or comfortable environment during continence care for Residents 8 and 9 as curtains were in place, and there was no suggestion from any party that they were not used.

Further the panel noted that there was no evidence of formal complaints or dissatisfaction from residents or their families and therefore the panel found this charge not proved.

Charge 2(b)(i)

b) 'The Home was below the expected standard in that:

  i) it required redecoration and/or building work'

This charge is found proved.

The panel acknowledged that the overarching responsibility for the condition and upkeep of the care home environment lay with the owner, Colleague 1. However, the panel also recognised that Ms. Blore, in her role as the Registered Manager, had a duty to identify, escalate, and act upon any concerns that affected the safety or wellbeing of residents, including the condition of the building. The panel viewed this as a shared duty, where Colleague 1 as the homeowner ensures resources and structural compliance, while the manager ensures risks are identified and communicated appropriately.

In Witness 1's statement there are photographs showing deterioration in parts of the building including poor conditions of paint work, holes in walls that require repair and badly worn carpets on the stairs. The panel is satisfied from the photographs it has seen that these defects are below the expected standards and raise concerns about safety for residents.

In response from Colleague 1's solicitor referencing the *"maintaining a safe environmental policy",* it was the duty of Colleague 1 to ensure that the Home is well maintained but it was Ms Blore's duty as Home Manager to bring any issues of concern to the attention of Colleague 1 which she had not done on many occasions. The panel concluded that while Ms. Blore was not responsible for the physical maintenance or funding of the building, she did have a professional obligation to escalate such issues. The panel found that in this respect she had failed to recognise or act upon the state of disrepair and had dismissed legitimate concerns about residents' safety raised by others.

Although the panel recognised that the Home was up for sale at the time of the inspection, which may have influenced Colleague 1's willingness to invest in repairs, it found that this did not absolve Ms Blore of her duty to advocate for the residents' safety. The Home was clearly below expected standards, as noted in the CQC inspection report, with visible signs of wear and lack of maintenance and therefore the panel found this charge proved.

Charge 2(b)(ii)

b) 'The Home was below the expected standard in that:

   ii) it was cluttered'

This charge is found NOT proved.

The panel considered the allegation that the Home was cluttered and reviewed both the photographic evidence and written statements which noted that the areas in question had been in similar use for 16 years.

Importantly, the panel noted that residents were still able to move around the Home without reported difficulty or apparent risk. Although the panel recognised isolated examples of cluttering, it was not satisfied, on the balance of probabilities, that the NMC had discharged the burden of proof to show that the clutter rendered the environment unsafe or unacceptable.

Whilst the panel acknowledged that some clutter was present in parts of the Home, it did not find it significant enough to conclude that the overall environment was unsafe or fell below the expected standard. It therefore found this charge not proved.

Charge 2(b)(iii)

b) 'The Home was below the expected standard in that:

iii) The wheelchair lift was not stored in the neutral position'

This charge is found proved.

The panel considered evidence including Witness 1's statement, which highlighted that the wheelchair lift was left in a raised position, as captured in the photographic evidence provided to the panel. Given the frailty and mobility limitations of many residents, some of whom had dementia, the panel agreed that leaving the wheelchair lift in this position presented a clear safety risk.

The panel determined that failing to store the lift in the neutral position contributed to an unsafe environment, especially in a setting where resident vulnerability should be closely managed. It therefore found this charge proved.

Charge 2(b)(iv)

b) 'The Home was below the expected standard in that:

iv) In respect of Residents 10 and 11, there were baby/security gates outside their room creating a risk of falls'

This charge is found proved.

The panel firstly considered the photographic evidence provided by Witness 1 and although it noted there was nothing to attribute them to Residents 10 or 11's specific

rooms, it accepted Witness 1's evidence and determined that the gates were in place as set out in the charge.

The panel reviewed the limited information provided to it, starting with Resident 10 who had Alzheimer's, Type 2 diabetes, lacked capacity, and was independently mobile. It next considered Resident 11, who had multiple sclerosis, epilepsy, short-term memory loss, and used a walking stick. Both residents presented with the risk of falling, and there was no risk assessment or evidence to explain why baby/security gates were used in their case.

Despite the lack of a formal risk assessment, the panel concluded that the use of baby/security gates outside the residents' rooms posed a foreseeable risk of falls given the particular vulnerabilities of these residents, therefore this charge is found proved.

Charge 2(b)(v)

b) 'The Home was below the expected standard in that:

v) there was insufficient signage for residents with a diagnosis of dementia'

This charge is NOT found proved.

The evidence before the panel in considering a charge based on sufficiency or insufficiency as it related to signage, was limited. The CQC had a view about the standard that is expected, but the precise nature and definition of this standard was not communicated to the panel.

The panel was provided with photographic evidence from Colleague 1's solicitor showing clearly illustrated signage which included pictorial representation of a dining table, with a directional arrow and the words *'dining room'*, as well as one with an image of a toilet, again with a directional arrow and the word *'toilet'*. It accepted that this was dementia friendly signage.

The panel determined that whilst there may have been insufficient signage in some areas of the Home not identified to the panel, the NMC had not discharged its burden of proof for the panel to be able to find the charge proved. It could not be satisfied that on the balance of probabilities the Home had insufficient signage for residents with dementia, and it therefore found this charge not proved.

Charge 2(b)(vi)

b) ‘The Home was below the expected standard in that:

vi) you failed to accept professional advice in respect of matters charged in 3)b)i) – v)’

This charge is found NOT proved.

The panel first considered the documentary and oral evidence of Witness 1. Her evidence described how Ms Blore was dismissive of concerns raised about resident safety and the environment. The panel accepted Witness 1’s account as credible and reliable.

However, while the panel agreed it was reasonable to expect the Home to respond appropriately to advice from CQC inspectors, it also concluded that this does not amount to a formal duty to follow such advice. In other words, failing to agree with or act on an inspector’s advice is not a breach of professional duty unless clearly mandated.

Therefore, although Witness 1 may have considered Ms Blore’s response to have been unwelcome and at times overly defensive, the panel found that the NMC had not proven a duty was breached, and as such this charge is found not proved.

Charge 2(b)(vii)

b) ‘The Home was below the expected standard in that:

vii) you failed to accept professional advice to ensure that the service was safe and/or challenge the provider in not creating an action plan to respond to the Fire Risk Assessment Report 2021.'

This charge is found proved.

The panel first considered whether Ms Blore had a professional duty to act in response to the 2021 Fire Risk Assessment Report. According to the job description included in the exhibits, Ms Blore had the responsibility:

"To ensure the fire regulations are complied with and eliminate any area of risk."

This duty supported the panel's view that she was expected to take appropriate action and that this was clearly articulated in her job description.

The evidence considered by the panel included a note from a discussion between the Witness 1, Colleague 1 (the Home provider) and Ms Blore on 19 January 2022. During that meeting, it is suggested that Colleague 1 dismissed the Fire Risk Assessment findings and refused to create an action plan. Ms Blore did not challenge this decision.

The panel noted that while Colleague 1's legal representatives claimed that the Home had complied with the fire assessment and that Derbyshire Fire & Rescue had signed off the Home in 2021. These appendices were provided to the panel for review.

The panel was provided with a copy of an enforcement notice issued on 20 May 2021 by Derbyshire Fire and Rescue Service outlining that the Home was unsafe in case of fire. This notice was subsequently withdrawn on 20 July 2021. The panel was also provided with a Fire Risk Assessment report conducted on 26 October 2021. This states:

“It is a statutory requirement for the Responsible Person/Duty Holder, to ensure that this risk assessment is review regularly by a competent person, so as to keep it up to date.”

The same report identifies Colleague 1 as the Responsible Person/Duty Holder.

Witness 1 acknowledged that it was the Home owner’s overall responsibility to act on the Fire and Rescue Service Report. However, Witness 1 asserted that Ms Blore, as Registered Manager, was responsible for ensuring that any concerns she had were escalated to the owner and that residents were always safe. Witness 1 discussed the Fire and Rescue Report with both Colleague 1 and Ms Blore, and it was Colleague 1 who stated that an action plan had not been created because he did not agree with the report, a statement which Ms Blore supported.

In her written statement, Witness 1 expressed concern over both Colleague 1’s dismissive attitude and Ms Blore’s failure to challenge it, particularly regarding safety measures like replacing non-compliant curtains. The panel was not presented with evidence by Ms Blore or Colleague 1 that Ms Blore did in fact challenge Colleague 1’s attitude towards the Fire Risk Assessment in order to accept the professional advice it was provided.

In conclusion, the panel determined that Ms Blore, as Registered Manager, had a clear duty to work collaboratively with Colleague 1 to ensure residents safety. Her failure to do so led the panel to find this charge proved.

Charge 3(a)

‘Placed restrictions on residents without adequate assessments in that:

a) In respect of Resident 1, there was no assessment to consider alternatives to bed rails’

This charge is found NOT proved.

The panel reviewed the evidence provided by Colleague 1 in the form of a bed rail assessment for Resident 1. This assessment explicitly asked whether the use of bedrails was the best solution and whether an alternative method could be used. Both questions were answered “yes” and “no” respectively confirming that alternatives had been considered and found not to be suitable.

Based on this documentation, the panel was satisfied that an adequate assessment had been carried out and that alternatives to bedrails were indeed considered. Therefore, the panel concluded that Ms Blore had not failed in this regard and therefore the panel found this charge not proved.

Charge 3(b)

‘Placed restrictions on residents without adequate assessments in that:

b) In respect of Residents 10 and 11, restricted their freedom of movement by placing baby/security gates on their bedroom doors, without a capacity and/or best interest assessment.’

This charge is found proved.

The panel considered the available evidence, including handover documents which confirmed that the mobility of both Residents 10 and 11 was limited.

The panel noted that there was no evidence of a capacity or best interests’ assessment being carried out to justify the use of such restrictive measures. The use of baby or security gates on their bedroom doors was deemed a clear restriction on their freedom of movement and therefore found this charge proved.

Charge 4(a)

‘On 18/19 January 2022, during the CQC inspection, failed to implement and/or promote infection control measures in response to the Covid 19 pandemic in that:

a) There was no social distancing by staff in the staff room/activities room’

This charge is found proved.

The panel carefully considered the evidence provided before it in relation to this charge, in particular the written statement of Witness 1, who attended the Home on 18 January 2022. Witness 1 stated that, upon arrival, she walked past the staff/activities room and observed several members of staff inside who were neither wearing masks nor adhering to social-distancing requirements. She further stated that, in her view, these failures placed service users at risk of infection due to poor infection prevention and control practices and a failure to comply with national Covid-19 guidance.

The panel found Witness 1’s evidence to be both credible and reliable. Her account was clear, detailed and consistent, and demonstrated a specific recollection of the events witnessed during the inspection.

The panel noted that, had Ms Blore been present to give evidence, it might have been able to get further clarity about the risks posed. It did not have key information from Witness 1 and was unable to question Ms Blore on such matters including the size of the staff room and the maximum number of individuals it could safely accommodate under Covid-19 guidance. However, no such information was available to the panel, and no alternative account or explanation was provided by Ms Blore in her response bundle.

The panel determined that the evidence available was sufficient to establish that staff were not socially distancing in the staff /activities room during the CQC inspection as directedly observed by Witness 1. It therefore found this charge proved.

Charge 4(b)

> 'On 18/19 January 2022, during the CQC inspection, failed to implement and/or promote infection control measures in response to the Covid 19 pandemic in that:
>
> b) There was no wearing of face masks by staff in the staff room/activities room

This charge is found proved.

The panel again considered the written statement of Witness 1, who stated that upon her arrival she observed, through the window of the staff room/activities room, several members of staff inside the room, none of whom were wearing masks or adhering to social-distancing guidance. Her account included the following description:

> *"Upon arrival to the home on 18 January 2022, I walked past, what I later learnt was, the staff room / activities room. I could see through the window that there were several members of staff in the room, none of whom were wearing masks or following social distancing guidance."*

The panel noted that Witness 1 did not provide precise details such as the number of staff present. The panel considered that such additional information would have been of further assistance. Nevertheless, the panel was satisfied that her evidence clearly conveyed that no staff members observed were wearing face masks at the relevant time.

The panel found Witness 1 to be a credible and reliable witness, whose account was coherent, consistent, and reflective of her professional observations as a CQC inspector. The panel therefore found this charge proved.

Charge 4(c)

> 'On 18/19 January 2022, during the CQC inspection, failed to implement and/or promote infection control measures in response to the Covid 19 pandemic in that:
>
> c) You wore a fabric mask instead of a fluid mask as directed by the Government'

This charge is found proved.

The panel considered all available evidence, including the representations submitted by Colleague 1 in the letter sent to the CQC following the inspection. In that document, Colleague 1 stated:

> *"In respect of the type of masks that were being worn by the Registered Manager and one other member of staff, cloth masks were worn in accordance with guidance as both had physical conditions amounting to an exception to the wearing of the clinical standard FFP3 masks. Rather than wearing no mask at all, both staff members wore a cloth mask to provide as much protection as possible for residents and others."*

The panel noted that Colleague 1 confirmed that Ms Blore was wearing a cloth mask on the date of the CQC inspection. The panel also observed that this was the only evidence before it regarding the type of mask Ms Blore wore. No evidence was presented to suggest that she was wearing a fluid-resistant surgical mask, which was the standard required by Government guidance for care home staff at the time. It further acknowledged that such guidance had changed frequently during the pandemic but consistently mandated medical-grade masks rather than fabric masks.

The panel further noted that while Colleague 1 explained that Ms Blore had a physical condition that was said to justify the use of a cloth mask, no supporting medical documentation or official exemption was provided. There was therefore no

evidential basis on which the panel could conclude that a fabric mask was permitted in Ms Blore’s circumstances.

On the balance of probabilities, the panel accepted on the evidence before it that Ms Blore was wearing only a cloth mask and therefore, it found this charge proved.

Charge 4(d)(i)

> ‘On 18/19 January 2022, during the CQC inspection, failed to implement and/or promote infection control measures in response to the Covid 19 pandemic in that:
>
> d) You demonstrated poor PPE practice when responding to an incident with Resident 1 in that:
>
> i) you failed to wear a fluid mask and/or’

This charge is found proved.

The panel reviewed the evidence of Witness 1, as well as relevant extracts from the CQC inspection report.

Witness 1 stated that PPE usage within the Home was consistently poor. She described observing staff who did not wear the correct type of mask and who failed to change their masks after contact with a Covid-19 positive resident. The CQC report stated:

> *“Staff did not use personal protective equipment (PPE) safely. PPE was not readily accessible throughout the home. We saw staff wearing fabric masks, including whilst supporting a person who had COVID-19. Staff did not change their masks, including whilst supporting a person who had COVID-19, increasing the risk of infection spreading to others.”*

Witness 1 further explained in her statement that shortly after Ms Blore attended to Resident 1, another member of staff entered the resident’s room wearing a fabric

mask. Witness 1 stated that she had reminded Ms Blore only minutes earlier of the requirement for staff to wear fluid-repellent masks. Despite this, Ms Blore did not intervene or instruct the staff member to change into appropriate PPE. Witness 1 also observed that after leaving the room, the staff member removed some PPE but continued her shift wearing the same fabric mask that had potentially been exposed to infection. Witness 1 stated:

> *"As the Home Manager, Ms Blore should have told the member of staff to remove the mask. These poor PPE practices increased the risk of infection spreading."*

The panel found Witness 1's account to be clear, credible, and consistent in her oral and written evidence.

The panel also acknowledged that considerable learning had taken place in relation to infection-control practices since the start of the Covid-19 outbreak in early 2020, and that standards of PPE use have improved over time. However, this did not change the panel's assessment of the practices observed at the time of this CQC inspection. Therefore, the panel found that Ms Blore failed to ensure appropriate PPE standards were maintained during the incident with Resident 1 and therefore found this charge proved.

Charge 4(d)(ii)

d) 'On 18/19 January 2022, during the CQC inspection, failed to implement and/or promote infection control measures in response to the Covid 19 pandemic in that:

    ii. you failed to ensure a member of staff involved in the incident wore a fluid face mask.'

This charge is found proved.

In relation to this charge the panel applied the same reasoning as set out in respect of Charge 4(d)(i). The evidence of Witness 1 demonstrated that a member of staff involved in the incident with Resident 1 was not wearing a fluid-resistant mask, and that Ms Blore failed to take appropriate action to ensure compliance with required PPE standards. This charge is therefore found proved.

Charge 4(e)

e) You failed to ensure measures were in place to identify if a resident had contracted Covid 19.

This charge is found NOT proved.

The panel reviewed all relevant evidence, including the written representations provided on behalf of Colleague 1. In this document Colleague 1's solicitor stated that Resident 1, who was 100 years old and Covid-positive, was not isolated due to the significant risks this would have posed to his mental health. The letter further stated that the Home operated an effective Lateral Flow Test (LFT) testing regime and that Resident 1 was likely the source of the Covid-19 outbreak within the Home.

The panel also had before it photographs of door signage, marked with an 'X' which were said to have been used to indicate where residents had tested positive for Covid-19. While the precise date on which these photographs were taken could not be conclusively established, the panel accepted that they were taken prior to March 2022 and appended to correspondence sent to the CQC.

The panel considered the reliability and evidential value of these photographs alongside the statement of Witness 1, who stated:

> "*Although Ms Blore informed me that there was a Covid-19 outbreak, there were insufficient measures in place to identify which residents had Covid-19. There was no identifier when walking around the building about which residents had Covid-19 (for example, no signs on the door)."*

The panel noted that the charge is framed in terms of whether measures were in place. While Witness 1 reported that there were insufficient measures, the panel found that some measures were, in fact, evidenced, namely the signage on the doors and the testing regime referred to in Colleague 1's representations. On the balance of probabilities, the panel concluded that the NMC had not discharged the burden of proving that no such measures existed. On this basis the charge is found not proved.

Charge 4(f)

f) 'You failed to follow the 'bare elbow guidance' in that you wore a long-sleeved T-shirt under your uniform.'

This charge is found proved.

The panel considered the allegation that Ms Blore failed to comply with the 'bare below the elbow' guidance by wearing a long-sleeved T-shirt underneath her uniform on 19 January 2022.

The panel noted that the requirement for staff to be bare below the elbow is long-standing clinical practice, integral to effective infection prevention and control. This standard supports proper handwashing and reduces the risk of contamination when supporting residents. The panel considered that, as a Registered Manager, Ms Blore would have been expected to be fully aware of and to adhere to this guidance.

The panel considered Witness 1's evidence, in which she described observing Ms Blore wearing a long-sleeved T-shirt under her uniform on 19 January 2022. Witness 1 explained that this was inconsistent with the national bare-below-the-elbow guidance in place at the time for health and care workers, and that such non-compliance increased the risk of infection spreading.

The panel placed weight on the credibility and reliability of Witness 1. Witness 1's observations were specific and contemporaneous. The panel had no reason to believe that the observation was inaccurate and accepted her account, on the balance of probabilities. The panel therefore found this charge proved.

Charge 4(g)

g) 'There were empty PPE stations in the Home.'

This charge is found NOT Proved.

The panel considered Witness 1's written statement which said:

> *"I had concerns about the fact there were empty PPE stations around the house and I attach a photograph taken of the PPE station outside Resident 1's room…"*

This charge is unspecific in that it does not identify a particular location but refers to multiple empty PPE stations. Witness 1 also provided a photograph of a PPE station that contained some single use gloves but was not completely empty.

The panel was provided with two further photographs of PPE stations from Ms Blore and Colleague 1. The first shows a PPE station on a landing, and the other shows a PPE station in a corridor which looks to be outside a resident's room. These photographs show masks, aprons, gloves, wipes, and a clinical waste bin in place. Based on this evidence the panel was unable to conclude that there were empty PPE stations in the Home, therefore the panel found this charge not proved.

Charge 4(h)

h) 'Fluid repellent masks were only available at the entrance to the Home.'

This charge is found NOT Proved.

The panel was provided with a photograph by Witness 1 of the Home's entrance hall, which showed a PPE station containing fluid repellent masks. The panel noted that Witness 1 took the photo during her inspection.

While the image demonstrated that such masks were available at the entrance, there was evidence to establish that that this was not the only location within the Home

where fluid repellent masks were provided. As set out in charge 4(g) the panel noted that, the existence of at least one other PPE station containing fluid repellent masks is material to this charge and would undermine the charge as drafted. The panel therefore found this charge not proved.

Charge 4(i)

i) 'Waste was not disposed of within infectious material bags in contravention of Government guidance on disposal of infectious materials.'

This charge is found proved

The panel took into account Witness 1's evidence that she discussed waste management with both the housekeeper and Ms Blore during the inspection. She expressed concerns that infectious material was being disposed of in yellow bags instead of orange bags, and that the Home was non-compliant with the national guidance for disposal of Covid-19 waste. According to Witness 1, Covid-19 waste should have been held for 72 hours prior to collection in orange-coloured bags and a failure to do so therefore posed a risk to infection transmission.

The panel also considered the representations made in Colleague 1's solicitor's letter, which stated:

> *"As regards safe disposal of infectious waste and the colours of disposal bags, the local Derbyshire IPC team informed the Home that orange bags were not needed as it was very hard to get hold of these. They confirmed that it was appropriate to use yellow bags and so long as these are double-bagged, it was appropriate and safe. The IPC team confirmed that double bagging in yellow bags and putting the bags outside securely in the yard area for at least 72 hours before collection."*

The panel was provided with two versions of the Home's waste policy: the Control of Waste Policy dated 24 January 2021, and an updated version dated 24 January 2022, revised in response to Covid-19. The panel noted that neither policy contained any reference to using orange bags, nor to the requirement cited by Witness 1 that

waste should be held for 72 hours before disposal. The Home's policies and procedures did not align with the infection-control requirements described in Witness 1's evidence.

The panel concluded that the evidence demonstrated that the Home's waste-disposal practices were not compliant with the standards in national guidance, and that Ms Blore had not ensured that appropriate measures were in place. The panel found this charge proved.

Charge 4(j)

j) 'The cluttered state of the Home inhibited effective cleaning.'

This charge is found NOT proved

The panel considered whether the cluttered state of the Home inhibited effective cleaning. The panel referred to its earlier finding under Charge 2(b)(ii), namely that the Home was not cluttered. The only additional evidence relevant to this charge was in Witness 1's statement, where she expressed concern that the presence of superfluous objects such as mobility aids and chairs located in bathrooms could increase the risk of infection by inhibiting effective cleaning.

The panel accepted that Witness 1 considered these items to pose a potential contamination risk. However, the panel also noted that the presence of mobility aids and similar equipment in bathrooms is to be expected within a care home environment and does not necessarily amount to clutter or indicate that effective cleaning cannot take place.

Further, whilst the panel previously noted that there were isolated examples of cluttering in other locations around the Home, it determined that this did not establish that such clutter did not inhibit effective cleaning, and therefore found this charge not proved.

Charge 4(k)

k) ‘There was no record of the vaccination status of those visiting the Home.’

This charge is found proved

The panel considered the evidence of Witness 1 who stated that Ms Blore did not maintain records of the vaccination status of visitors, including healthcare professionals and agency staff, despite the Home being required to do so during Covid-19 outbreak.

The panel noted that Colleague 1 had submitted a visitors’ log for six visitors dated 17 May 2021. Whilst these logs recorded certain details such as the outcome of lateral flow tests, they did not include any information regarding visitors’ vaccination status.

The panel accepted Witness 1’s evidence that care services were required to keep records of visitor vaccination status, and therefore that Ms Blore had a duty to ensure that such records were maintained. The documents provided did not demonstrate compliance with this requirement.

On the balance of probabilities, the panel concluded that the required records were not being kept and therefore found this charge proved.

Charge 4(l)

l) ‘The Home’s Infection Prevention and Control Policy was inadequate in that there was no guidance on cleaning, admissions and/or Covid 19 prevention.’

This charge is found proved

The panel considered whether the Home’s Infection Prevention and Control (IPC) Policy was inadequate, particularly in relation to guidance on cleaning, admissions, and Covid-19 prevention.

Witness 1 stated that although the Home did have an IPC Policy, it was insufficient. She noted that the only section addressing Covid-19 was a brief paragraph which did not provide the level of detail required to support staff in managing infection risks. Witness 1 further explained that she would expect an adequate IPC policy to contain clear guidance on matters such as waste management, cleaning procedures (including what products to use and how to clean different areas), and the process for hospital admissions when a resident had Covid-19. She also highlighted that the policy was dated January 2021 and had not been updated for over twelve months, despite significant changes in national guidance during that period. As the Registered Manager and a registered nurse, Ms Blore was responsible for ensuring that the policy was current and that staff were supported by appropriate infection control guidance.

The panel considered the IPC policy and found it reasonable to conclude that Ms Blore had a duty to ensure the policy was updated and sufficiently comprehensive. Although an updated version was produced dated 24 January 2022, this was introduced only after the inspection and did not address the deficiencies identified at the time. The panel further noted that neither the owner nor their solicitor responded substantively to the concerns raised in this charge, aside from providing the updated policy, and no explanation was offered for the lack of adequate guidance in the earlier version.

The panel concluded that the policy in place at the time of the inspection lacked essential and up to date guidance on admissions, cleaning procedures, and Covid-19 prevention measures, rendering it inadequate. The panel therefore found this charge proved.

Charges 5(a)(i) and 5(a)(ii)

> ‘On 19 January 2022, failed to keep accurate and/or up to date recruitment records in that:
>
> a) 2 recruitment files did not contain:

(i) Second references
(ii) Full employment history’

These charges are found proved

The panel examined whether Ms Blore failed to keep accurate and up to date recruitment records, specifically in relation to the absence of second references and full employment histories in two staff recruitment files.

The panel reviewed the evidence of Witness 1, who stated that during the inspection on 19 January 2022 she examined two recently completed recruitment files. She observed that both files were missing second references and did not contain a complete employment history. When she asked Ms Blore about these omissions, Ms Blore responded that she did not know she was required to keep this information.

The panel considered that, as the Registered Manager, Ms Blore had a clear responsibility to ensure the Home maintained accurate recruitment documentation in line with safe recruitment and employment practices. The panel had sight of Ms Blore’s job description, which reinforced this duty.

Although no additional documentary evidence, such as copies of the deficient recruitment files was provided, the panel found Witness 1’s evidence to be credible and reliable. As a CQC inspector, her observations were made contemporaneously and were consistent with regulatory expectations.

The panel concluded that the deficiencies identified amounted to a failure to maintain proper recruitment and employment records and therefore fell short of the standards expected of a Registered Manager. The panel therefore found charges 5a(i) and 5a(ii) proved.

Charge 5(a)(iii)

‘On 19 January 2022, failed to keep accurate and/or up to date recruitment records in that:

a) 2 recruitment files did not contain:

iii) DBS checks’

This charge is found NOT proved

The panel considered whether Ms Blore failed to keep accurate and up to date records of Disclosure Barring Service (DBS) checks.

Witness 1 stated that in both of the recruitment files she reviewed, the date on which DBS checks were obtained and confirmation of whether the checks were clear had not been recorded. She explained that she would expect the Registered Manager to have this information, including the DBS number, the date of completion, and confirmation of the outcome. Witness 1 also reported that, when questioned, Ms Blore stated she did not know she was required to keep this information.

However, the panel noted that Witness 1’s account did not indicate that DBS checks themselves were missing. Rather, her evidence suggested that the checks had been completed and were available for inspection, but that certain administrative details had not been recorded.

The panel considered that the primary duty in relation to DBS checks is to ensure that they are carried out. The evidence before it did not demonstrate that DBS checks had not been undertaken, as set out in the stem of the charge. The panel therefore found this charge not proved.

Charges 6(a) and 6(b)

‘On 19 January 2022, you failed to demonstrate that staff had sufficient training in one or more of the following areas:

a) Infection control and prevention
b) safeguarding adults’

These charges are found proved

The panel examined whether Ms Blore failed to demonstrate that staff had sufficient and up to date training in key areas, specifically infection control and prevention and safeguarding adults.

The panel had before it the Home's training matrix/audit and a copy of the CQC inspection report, which stated in full:

> *"Many staff did not have up-to-date training in key areas. For example, 12 members of staff had not had any IPC training since the start of the pandemic. Eight staff had not had any safeguarding adults training since 2018. We found significant issues with both IPC and safeguarding during inspection. This lack of training had a negative impact upon staff competency."*

The panel also considered the relevant regulatory requirement, namely Regulation 18: Staffing, which states:

> *"Training, learning and development needs of individual staff members must be carried out at the start of employment and reviewed at appropriate intervals during the course of employment. Staff must be supported to undertake training, learning and development to enable them to fulfil the requirements of their role. When appropriate, staff must be supervised until they can demonstrate required and acceptable levels of competence to carry out their role unsupervised."*

The panel reviewed Witness 1's evidence, including the training record she was provided with during the inspection. Witness 1 stated that Ms Blore had not ensured staff received essential training, supervision, or development. She highlighted gaps in infection prevention and control training and safeguarding adults training on specific needs relevant to residents living in the Home. She emphasised that, as Registered Manager, Ms Blore had overall responsibility for ensuring staff competency.

The panel observed that the Home operated a three yearly cycle for infection control training. Whilst the panel acknowledged that determining what constitutes an *‘appropriate interval’* for refresher training under Regulation 18 may be subject to interpretation, it concluded that, in the context of the Covid-19 pandemic, a three-year cycle fell significantly short of safe practice. The panel further noted that safeguarding training had not been completed by several staff members since 2018, which could not be considered compliant with regulation or good practice.

The panel considered two possible interpretations of *“insufficient”* training:

1. Whether every staff member lacked required training at the time of the inspection; or
2. Whether staff lacked the training necessary to safely fulfil their roles, as understood under Regulation 18.

The panel preferred the second interpretation, as aligning with the regulatory focus on ensuring staff possess the competence needed to promote safe care. The panel also recognised that, although Regulation 18 sets a minimum standard, health and social care settings are expected to follow good practice, particularly in areas such as infection prevention and safeguarding where lapses pose immediate risks.

Based on the evidence before it, the panel found clear training gaps in both infection control and safeguarding adults at the time of the inspection. These gaps demonstrated that staff were not adequately trained in these core areas and that Ms Blore had failed to ensure staff competency in accordance with her responsibilities as Registered Manager. The panel therefore found charges 6a and 6b proved.

Charge 6(c)

‘On 19 January 2022, you failed to demonstrate that staff had sufficient training in one or more of the following areas:

c) pressure area care’

This charge is found proved.

The panel first considered Witness 1’s statement which set out that, *“…others did not have training on safeguarding adults or pressure area care.”.* The panel recognised that pressure area care was noted on the training matrix as tissue viability training, and noted that these terms are used interchangeably.

The panel noted that the training records identified that pressure area care training had been booked for some staff. However, the panel considered that evidence of training merely being booked did not demonstrate that the training had been completed. In line with good practice and the aforementioned requirements of Regulation 18, the Registered Manager was expected to ensure that staff had actually undertaken training necessary to fulfil their roles safely.

Given the absence of evidence confirming that pressure area care training had been completed, the panel concluded that Ms Blore had failed to demonstrate that staff had sufficient training in this area. The panel therefore found this charge proved.

Charge 6(d)

> ‘On 19 January 2022, you failed to demonstrate that staff had sufficient training in one or more of the following areas:
>
> d) specific needs’

This charge is found proved.

The panel’s understanding of this charge is that training relating to supporting residents with specific needs, such as brain injuries or learning disabilities had not been undertaken.

The panel reviewed the training matrix/audit and noted that only evidence of certain staff receiving specific training related to domestic staff completing COSHH training and registered nurses receiving administration of medicines training.

Despite the presence of such role-specific training some members of staff, the panel did not find evidence in the Home's training records of training given to staff in respect of residents' specific needs. The panel was therefore satisfied that Ms Blore had failed to demonstrate that staff had sufficient training in the area of specific needs and therefore found this charge proved.

Charge 7

> 'Failed to supervise the competency of staff to provide safe care and/or treatment in that formal supervision was only completed once a year.'

This charge is found NOT proved.

The panel considered the allegation that Ms Blore failed to supervise the competency of staff to provide safe care and/or treatment in that formal supervision was only completed once a year.

The panel reviewed Witness 1's evidence, in which she stated that formal staff supervision occurred annually and that this frequency, in her view, risked missing opportunities to identify and address poor practice.

Witness 1 stated that Ms Blore told her she did not consider annual supervision to be an issue.

The panel reviewed Ms Blore's job description, which stated in full:

> *"To ensure that effective induction, supervision and assessment of staff is carried out and that training needs are identified and met."*

The panel noted that the dispute centred not on whether staff were supervised at all, but on the frequency of formal supervision. Witness 1 acknowledged in her statement:

> *"I can confirm that there is no statutory requirement on frequency of staff supervision. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states as follows:*
>
> *18.—(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.*
>
> *(2) Persons employed by the service provider in the provision of a regulated activity must—(a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform."*

Whilst Witness 1 expressed the view that infrequent supervision may have contributed to poor practice, the panel noted that her evidence on this charge contained contradictions, particularly her acknowledgement that no statutory requirement exists regarding the frequency of supervision. The charge before the panel was specific and concerned an alleged failure arising from the annual frequency of formal supervision.

The panel took account of evidence from Colleague 1, notably the Home's Staff Supervision Policy which included the following statement in relation to appraisals:

> *'We expect our staff to participate in an annual appraisal session.'*

This policy document provided examples of how staff are supervised in the Home on a continual basis by the nurse in charge. The panel was of the view that this policy confirmed that ongoing developmental conversations would have taken place between Ms Blore and the Home staff on a more frequent basis, and these would not have been reserved just for the annual supervision

The panel did not accept Witness 1's assertion that Ms Blore failed in her duty because formal supervision was only completed once a year. The panel therefore found this charge not proved.

Charge 8(a)

Failed to safeguard residents from harm and/or neglect in that:

a) In respect of Resident 4, following an incident on 29 December 2021, you failed to investigate and/or refer to safeguarding.'

This charge is found proved.

The panel considered that whether Ms Blore failed to safeguard Resident 4 by not investigating or referring an incident that occurred on 29 December 2021.

The panel had before it Resident 4's personal documentation from the Home, which included assessments identifying that he didn't use mobility aids, mobilised using furniture, and had been assessed in relation to continence, sitting and standing ability, and walking. While assessments had been carried out and recorded, there was no corresponding care plan in place addressing the risks identified.

The panel also reviewed the accident report relating to the incident involving Resident 4. Witness 1 confirmed that this incident report evidenced that a fall had occurred. However, there was no documentation of any follow up investigation or safeguarding referral being made.

The panel next considered Ms Blore's job description, which stated in full:

'To promote a caring environment for residents through high standards of professional practice that are conducive to the physical, emotional, social, intellectual and spiritual needs of the residents.'

The panel also considered the relevant provisions of the NMC Code, including section 16:

> ***'16: Act without delay if you believe that there is a risk to patient safety or public protection.***
>
> > *16.4: Acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so.'*

These provisions placed a clear professional duty on Ms Blore, as a Registered Manager, to identify safeguarding concerns, investigate incidents, and escalate matters where necessary to protect residents from harm.

The panel found that while the fall was recorded, there was no evidence of any subsequent investigation or safeguarding referral. Witness 1 confirmed that nothing had been documented to show that Ms Blore took any safeguarding action following the incident. Given her role, responsibilities, and the requirements of the NMC Code, she had a clear duty to take such action. She failed to do this and therefore the panel found this charge proved.

Charge 8(b)

Failed to safeguard residents from harm and/or neglect in that:

b) In respect of Resident 13, following incidents on or around 13/14 April 2021 and/or 16 April 2021, you failed to investigate and/or refer to safeguarding.

This charge is found proved.

The panel examined whether Ms Blore failed to fulfil her safeguarding responsibilities by not investigating or referring the incidents involving Resident 13 that occurred on or around 13/14 April 2021 and/or 16 April 2021.

The panel had before it the relevant incident reports, which confirmed that incidents involving Resident 13 had been recorded. However, there was no evidence of any follow up investigation, analysis of causation, or referral to the local safeguarding authority.

As with Charge 8(a), the panel considered that Ms Blore's safeguarding duties were clearly set out in her role as Registered Manager, which included promoting a safe environment and acting without delay where residents may be at risk of harm. The requirements of the NMC Code reinforced this, specifically the duty to investigate, escalate, or take appropriate action when concerns arise.

The panel found no documentation showing that Ms Blore had taken any safeguarding action in response to these incidents. There was no evidence of an internal inquiry or referral, nor any indication that she had taken steps to mitigate ongoing risks to Resident 13 or others and therefore it found this charge proved.

Charge 8(c)

'Failed to safeguard residents from harm and/or neglect in that:

c) In respect of Resident 14, following an incident on 29 December 2021, you failed to investigate and/or refer to safeguarding.'

This charge is found NOT proved.

The panel noted there may have been a typographical error resulting in an effective duplication of charge 8(a). It was unable to identify any evidence relating to a Resident 14, and accordingly found the charge not proved.

Medication

Charge 9

9) ‘In respect of Resident 8, there was no guidance in their care plan about when and/or why they should be given their prescribed medication (PRN Haloperidol).’

This charge is found proved.

The panel considered the allegation that Resident 8’s care plan did not contain guidance on when or why PRN Haloperidol should be administered. The panel reviewed Witness 1’s evidence, in which she stated that Resident 8 was prescribed PRN Haloperidol for agitation but that there was no corresponding guidance in the care plan, no behaviour chart, and no notes recorded on the MAR chart explaining the rationale for administration. Witness 1 reported that Resident 8 had received the medication 13 times in the preceding four weeks and raised concerns that, without proper documentation, she could not be assured that the medication was being used as a last resort.

The panel noted, however, that it had not been provided with a copy of Resident 8’s care plan but it accepted Witness 1’s statement. Instead, the panel had before it Resident 8’s PRN ‘when required’ medication protocol and the MAR chart. The MAR chart detailed the reasons for giving PRN Haloperidol (for agitation) and how often it could be given. Whilst the panel accepted that the MAR chart formed part of Resident 8’s care records, on a strict interpretation of the charge, the guidance was not in Resident 8’s care plan.

On the basis on which the charge was drafted the panel found this charge proved but it considered that the information was contained in a document where it would be readily accessed at the point of administration.

<u>Documentation</u>

Charge 10(a)(i)(ii)(iii)(iv)(v)

10) Failed to keep clear and accurate resident records in that:

a) On 18/19 January 2022, you failed to ensure there was in place and/or failed to make available, a Covid 19 plan, falls risk assessment, malnutrition chart, waterlow assessment and/or moving and handling assessment in respect of the following residents:

   i) Resident 1
   ii) Resident 3
   iii) Resident 5
   iv) Resident 6
   v) Resident 7

This charge is found NOT proved.

The panel first reviewed the documentation available for each of the five residents and noted that all key risk assessments had been completed.

- For Resident 1, it found evidence of personal handling, Waterlow, and falls risk assessments had been recorded.
- Resident 3's file contained the initial assessment, moving and handling, falls risk, nutrition score, Waterlow score, and personal handling.
- Resident 5's records included moving and handling, falls risk, and nutrition risk assessments.
- Resident 6 had nutrition, moving and handling, and Waterlow assessments
- Resident 7's file included falls risk, nutrition risk, personal handling, and Waterlow assessments.

The panel was therefore satisfied that for all five residents the essential risk assessments, relating to falls, nutrition, moving and handling, and Waterlow were in place and completed within a reasonable timeframe after their admission to the Home.

The panel observed that no evidence had been presented demonstrating a requirement for the Home to produce a Covid-19 plan for each individual resident.

The panel therefore found no factual or regulatory basis to support this component of the charge.

The panel gave careful consideration to the wording of the charge, particularly the phrase ‘failed to make available’. The panel interpreted this wording as suggesting intentional withholding or a failure to provide documents upon request.

In this context, the panel examined the oral evidence of Witness 1. Her evidence was that she gave Ms Blore the names of the specific residents whose documentation she wished to see. She did not request particular documents, such as a falls risk assessment or Waterlow assessment but instead asked more broadly for *“care plans and risk assessments.”*

Witness 1 confirmed that Ms Blore opened a cupboard containing all resident files, provided full access, and remained available in the office whilst Witness 1 reviewed documentation. Witness 1 confirmed she had free access to all files throughout the inspection and that Ms Blore did not refuse access to any information.

Based on this evidence, the panel found no indication that Ms Blore withheld documents or failed to make them available when requested.

The panel reviewed all available risk assessments for the five residents. These included falls assessments, Waterlow assessments, nutrition risk scores, and moving and handling assessments. The panel was satisfied that these assessments had been completed and were available during the inspection period.

Colleague 1 later made available to the CQC documents evidencing, completed assessments for each resident, suggesting transparency rather than concealment.

The panel determined that the required assessments were in place for Residents 1, 3, 5, 6, and 7, and the evidence did not support that any documentation was not made available. There was no indication that Ms Blore failed to cooperate with Witness 1 in this regard.

Witness 1 appears not to have asked for specific assessments such as a falls risk assessments for individual residents but instead requested care plans and risk assessments in general terms, all of which were made available to her during the inspection. On this basis this charge is found not proved.

Charge 10(b)

10) ‘Failed to keep clear and accurate resident records in that:

   b) On 18/19 January 2022, in respect of Resident 8, failed to ensure there was a behaviour chart in place.'

This charge is found NOT proved.

In considering this charge, the panel first considered whether Ms Blore had a defined duty or responsibility to ensure that a behaviour chart was in place for Resident 8.

The panel noted that Witness 1 referred to the need for behavioural records as part of Resident 8’s documentation; however, no evidence was provided to show that keeping a behaviour chart was a required part of Ms Blore’s duties. Although the panel did not have sight of a behaviour chart relating to Resident 8, the absence of one could not therefore amount to a failure. Moreover, Witness 1’s observation alone did not create or prove that such a duty existed. The panel therefore found this charge not proved.

Charge 10(c)

10) ‘Failed to keep clear and accurate resident records in that:

   c) In respect of Resident 12, failed to ensure that their care plan was updated to reflect the recommendation for a level 4 pureed diet from July 2021.’

This charge is found proved.

In considering this charge, the panel first took into account the evidence of Witness 2. She referred to the professional duty set out in the NMC Code, which requires nurses to "*keep clear and accurate records relevant to your practice.*" Witness 2 further stated that, although Ms Blore could have delegated the task of updating the care plan to another nurse, she nevertheless remained responsible for ensuring that the update was completed accurately.

The panel also noted that Witness 2 identified the source of the information relating to Resident 12's need for a level 4 pureed diet namely, a recommendation from the Speech and Language Therapy (SALT) team in July 2021. Witness 2 went onto say that she gave a clear explanation as to why this recommendation should have been reflected in the resident's care plan and stated that the care plan had not been updated accordingly.

Although the SALT recommendation and the care plan itself were not provided to the panel, Witness 2's statement was detailed, internally consistent, and written in a manner that allowed the panel to attach appropriate weight to her account. The panel therefore accepted the plausibility and reliability of this hearsay evidence.

The panel concluded that Ms Blore failed to ensure that Resident 12's records accurately reflected their assessed dietary needs and found this charge proved.

Charge 11(a)

11) 'On 15 January 2022, recorded/or allowed to be recorded one or more of the following comments which were derogatory and/or inappropriate:

a) Kleptomaniac' to describe Resident 11.'

This charge is found NOT proved.

The panel reviewed the evidence in relation to the allegation, including the handover sheet as well as the CQC inspection report, which stated:

“The management team had not created a culture of high quality, person-centred care. Records of care and support were written in a judgemental manner. The handover sheet referred to people using derogatory language, such as ‘unkempt’, ‘attention seeking’, ‘kleptomaniac’, ‘psychotic’ and ‘vacant’. Use of traditional, outdated language in care records did not promote a positive culture.”

The panel first considered the handover sheet, which was presented in two columns: one labelled medical history and the other comments. In the medical history column, written by Ms Blore, Resident 11 was described as *‘kleptomaniac’*. In the comment’s column, the following observations had been recorded:

‘can be childlike; mobile with stick; constantly going to the toilet; double incontinent; can be sexually inappropriate.’

The panel carefully considered the purpose and function of a handover sheet and came to the view that such documents typically serve as concise summaries to assist staff in understanding key needs, risks, and priorities during handover. In this context, the panel concluded that the medical history column will often contain clinical information alongside wider observations about the patient or resident that is relevant to their care.

The panel next considered whether the term ‘*kleptomaniac’* was derogatory. It noted that although the word may appear blunt and could be perceived as harsh, it is also a recognised clinical term associated with a diagnosed condition involving recurrent stealing. The panel received no reliable evidence, beyond Witness 1’s assertion, to establish that this was not an accurate clinical descriptor in Resident 11’s case. The panel therefore could not conclude that its use was necessarily inappropriate or intentionally disrespectful.

The panel further noted that it could not determine the subjective intention of the person who wrote the term. There was no evidence to indicate that it had been used maliciously or with the purpose of demeaning the resident.

The panel also considered that the information recorded in the medical history section appeared to serve as shorthand, was in this case accurate and reflective of staff attempts to summarise relevant behaviours for the purposes of safe care.

Accordingly, on the balance of probabilities, the panel found that the evidence did not establish that the term *'kleptomaniac'* or any other entries amounted to derogatory or inappropriate comments and therefore found this charge not proved.

Charge 11(b)

> 11) 'On 15 January 2022, recorded/or allowed to be recorded one or more of the following comments which were derogatory and/or inappropriate:
>
> > b) Sexual deviant' and 'rude' to describe Resident 2.'

This charge is found NOT proved.

The panel considered the evidence relating to Resident 2, including Witness 1's statement and the CQC inspection report, which highlighted concerns that some care records contained judgemental or outdated language that did not support a positive, person-centred culture.

The panel also reviewed Resident 2's daily notes, which included entries describing him as *'rude and verbally abusive'*, *'vocal, rude and sexual'* and, in one record made on 13 January, as displaying *'inappropriate behaviour and sexually deviant'* conduct.

The panel then examined Resident 2's care plan which stated the purpose of the plan was to summarise Resident 2's presentation, including the following statement:

> *'He is extremely sexually inappropriate both verbally and physically, to both staff and residents, men and women. Everyone needs to be chaperoned when attending and he is on constant behavioural charts.'*

The panel noted that this behaviour was documented from the day of Resident 2's admission on 6 January 2022, and behaviour charts similarly recorded ongoing sexually inappropriate behaviour up to 14 January 2022.

On 15 January 2022, the date specified in the charge the panel had no evidence that any notes referring to *'sexual deviant'* or *'rude'* were recorded on that day. However, the panel accepted that the resident displayed a consistent pattern of sexually inappropriate behaviour, evidenced from admission and recorded through to 14 January.

The panel next considered whether the terms used were derogatory. It noted that the word *'deviant*' is defined as '*departing from usual or accepted standards, especially in social or sexual behaviour'.* When viewed objectively against the recorded pattern of behaviour of this particular resident and the content of the care plan, the panel considered that the notes appeared to be well meaning, accurate and shorthand descriptions of actual behaviour, rather than recorded in intentionally malicious or judgemental language.

The panel also found no evidence that the author intended to demean Resident 2. The wording used, while stark, appeared to be a factual and brief references to actual risk posing behaviours relevant to staff safety.

As with the previous charge, the panel concluded that, given the dictionary definitions of the terms within the charge, the contemporaneous documentation, and the absence of any observable malicious intent, the comments of themselves did not amount to inappropriate or derogatory language and therefore the panel found this charge not proved.

Decision and reasons on service of Notice of Hearing

The panel was informed at the start of this hearing that Ms Blore was not in attendance and that the Notice of Hearing letter had been sent to Ms Blore's registered email address on 10 December 2025.

Mr Hoskins, on behalf of the Nursing and Midwifery Council (NMC), submitted that it had complied with the requirements of Rules 11 and 34 of the 'Nursing and Midwifery Council (Fitness to Practise) Rules 2004', as amended (the Rules).

The panel accepted the advice of the legal assessor.

The panel took into account that the Notice of Hearing provided details of the allegation, the time, date and that the hearing was to be held virtually, including instructions on how to join and, amongst other things, information about Ms Blore's right to attend, be represented and call evidence, as well as the panel's power to proceed in her absence.

In the light of all of the information available, the panel was satisfied that Ms Blore has been served with the Notice of Hearing in accordance with the requirements of Rules 11 and 34.

The hearing resumed on 30 March 2026.

Decision and reasons on proceeding in the absence of Ms Blore

The panel next considered whether it should proceed in the absence of Ms Blore. It had regard to Rule 21 and heard the submissions of Mr Hoskins who invited the panel to continue in the absence of Ms Blore.

Mr Hoskins pointed to anomalies in details of the email addresses used to communicate with Ms Blore, that assured the panel that whilst it had been sent to her previous employer after she had left its employment, it had also been sent to her personal email address. This is the same email address that had been used previously by the NMC.

The panel accepted the advice of the legal assessor.

The panel noted the email anomaly in the information before it but did not consider this to be consequential. It used its discretionary power to proceed in the absence of

a registrant under the provisions of Rule 21 is not absolute and is one that should be exercised 'with the utmost care and caution'

The panel decided to proceed in the absence of Ms Blore. In reaching this decision, the panel considered the submissions of Mr Hoskins, and the advice of the legal assessor. It had particular regard to the factors set out in the decision of *R v Jones* and *General Medical Council v Adeogba* [2016] EWCA Civ 162 and had regard to the overall interests of justice and fairness to all parties. It noted that:

- No application for an adjournment has been made by Ms Blore;
- There is no reason to suppose that adjourning would secure her attendance at some future date; and
- There is a strong public interest in the expeditious disposal of the case.

There is some disadvantage to Ms Blore in proceeding in their absence. Although the evidence upon which the NMC relies will have been sent to her at her registered address. She will not be able to challenge the evidence relied upon by the NMC and will not be able to give evidence on their own behalf. However, in the panel's judgement, this can be mitigated. The panel can make allowance for the fact that the NMC's evidence will not be tested by cross-examination and, of its own volition, can explore any inconsistencies in the evidence which it identifies. Furthermore, the limited disadvantage is the consequence of Ms Blore's decisions to absent herself from the hearing, waive her rights to attend, and/or be represented, and to not provide evidence or make submissions on her own behalf.

In these circumstances, the panel has decided that it is fair to proceed in the absence of Ms Blore. The panel will draw no adverse inference from Ms Blore's absence in its findings of misconduct and impairment.

Fitness to practise

Having reached its determination on the facts of this case, the panel then moved on to consider, whether the facts found proved amount to misconduct and, if so,

whether Ms Blore's fitness to practise is currently impaired. There is no statutory definition of fitness to practise. However, the NMC has defined fitness to practise as a registrant's ability to practise safely and effectively without restriction.

The panel, in reaching its decision, has recognised its statutory duty to protect the public and maintain public confidence in the profession. Further, it bore in mind that there is no burden or standard of proof at this stage and it has therefore exercised its own professional judgement.

The panel adopted a two-stage process in its consideration. First, the panel must determine whether the facts found proved amount to misconduct. Secondly, only if the facts found proved amount to misconduct, the panel must decide whether, in all the circumstances, Ms Blore's fitness to practise is currently impaired as a result of that misconduct.

Submissions on misconduct

In coming to its decision, the panel had regard to the case of *Roylance v General Medical Council* (No. 2) [2000] 1 AC 311 which defines misconduct as a *'word of general effect, involving some act or omission which falls short of what would be proper in the circumstances.'*

Mr Hoskins invited the panel to take the view that the facts found proved amount to misconduct. The panel had regard to the terms of 'The Code: Professional standards of practice and behaviour for nurses and midwives 2015' (the Code) in making its decision.

Mr Hoskins identified the specific, relevant standards where Ms Blore's actions amounted to misconduct.

Mr Hoskins provided the panel with written submissions which in summary were that:

> *"The Panel have already found in respect of many charges and by their very careful analysis of the origin and extent of duties and obligations (derived*

either from legislation, regulations identified by the CQC inspector, national guidance in respect of COVID, Ms Blore's job description, the NMC code or general expected practice) that, by virtue of the use within the charges using the "failed" formulation, that there was a duty on Ms Blore which she had breached. In this way her actions constitute a falling short of what would be proper in the circumstances almost by definition of the charges.

Moreover, the extent of this falling short was not esoteric or technical and is instead serious, because:

a.The facts found proved demonstrate failings that affected a significant proportion of the Residents. 9 Residents are mentioned specifically in the charges and, given the Home accommodated only 20 Residents this is substantial. Furthermore, many of the matters found proved were systemic regarding, for example, infection control, the environment of care or training deficiencies and, therefore, can properly be regarded as affecting the totality of the Resident population.

b.The allegations found proved cover a broad range of themes for which Mr [sic] Blore was responsible and failed to discharged [sic] that responsibility adequately. These themes are disparate in nature rather than a single identifiable area of care: such as matters risk assessments deficiency, the standard of the premises and equipment, infection control, staff training and safeguarding, medication (albeit in a single respect) and documentation in respect of matters such as diagnosis identification and diet requirements. Even taken individually, some of these charges present real risks to the safety and wellbeing of the Residents. The CQC inspection report aptly summarises this in its overall finding that the Registrant "does not have the competence, skills or experience required to carry out their role" and "did not ensure that residents' needs were being met safely".

c.Although the charges are largely derived from the findings of a single inspection (backed up by the infection control inspection in March 2022) this permitted sufficient opportunity to look back at concerns over a broader time

period as reflected in the charges derived from what was documented during an earlier period rather than just on a single day. It is also submitted that what was identified on that day were highly unlikely to have been a monetary lapse or a "blip", for example the state of repair of the premises and the duty on the Registrant to escalate this and, as another example, the Panel's findings in respect of the age of the infection control policy in the context of a pandemic.

d.As well as wide ranging in theme, residents affected and not insubstantial in terms of time period, the failings were fundamental, even so far as to say basic, such as the accurate identification of Resident 7's diagnosis or the Registrant's own use of unjustified infection control measures.

e.Ms Blore was an experienced nurse who qualified in the year 2000, had been working in the home from 2011 and as manager from 2014. She would rightly be expected, therefore, to have provided a reasonable standard of care to patients. Moreover, the charges to do with training and competence of staff (charges 5 and 6) meant that there was very little guarantee that the deficiencies at a senior level and in governance would be rectified by a diligent and well-trained autonomous workforce below this level;

f. As well as experience, the position that Ms Blore held was a senior and pivotal one; she was joint registered manager with [Mr 1] (and the Committee have been careful to identify the respective responsibilities in this regard, for example in respect of charge 4) and separate to this was Clinical Lead (in circumstances where [Mr 1] appears to have no clinical background). The NMC submit that in the very matters that were the subject of the CQC inspection she was uniquely placed to feed into the safeguarding and clinical aspects of the running of the home.

g. The residents in [the Home] were vulnerable, catering as it did for elderly and end of life care.

h. There is relevant context within which to place this misconduct in that:

i.In the time period shortly before the CQC inspection, the home had taken in a relatively large number of new admissions. However, this was ultimately a decision about which Ms Blore had input given her seniority and if she had recognised the safety concerns that would follow she should have refused such admissions. As [Witness 2] told the panel (although noting pressures on the system arising from being at the height of winter bed pressures "They are independent providers and can absolutely say no at any stage to any admission". Furthermore, the period of time between admissions and the inspection was not insignificant. To the extent that there is the assertion that upon handover there simply wasn't sufficient information to conduct care planning, this was doubted by [Witness 1];

ii. The history of the home was one of CQC inspections which consistently indicated it required improvement. While this is true even before the Registrant became Home Manager, as outlined above given her length of service in post, this is not a case where the Registrant was new in post or didn't have knowledge or control over the very matters that were the subject of past inspections. Clearly the Registrant is not charged with any past deficiencies, but the real point in this context is that the failings identified cannot properly be said to have occurred in a vacuum, without concerns being identified in the past or arising from a short lived identifiable contextual factor. Indeed, some concerns had been the subject of notice to the Registrant (notably the matters identified in fire inspection reports or concerns about the standard of the care environment) but had not led to change. This pattern is repeated in respect of the Committee's findings about the re-drafting of the Infection Prevention and Control ("IPC") policy in light of the Inspection dated 24 January 2022 (p.49 of the reasons), which still did not address the identified and serious inadequacies. There is a pattern of here of resistance to or inability to institute change in

Resident Care;

iii. The period that the Committee are concerned with came on the back of strains being put on homes such as [the Home] throughout the period of the

COVID 19 pandemic, as they have identified in their factual findings. Yet it is difficult to see this is an all encompassing cause of deterioration in two respects: firstly, given the findings in relation to Charge 4 it was very much on addressing the COVID 19 threat that there were identifiable failings; secondly, the time of the inspection and period of identifiable shortcomings was many months after the initial threat of COVID. By the period with which the panel are primarily concerned, this was a known threat and while regulations and expectation changed in detail, the pressure on the service was known and familiar.

iv.One contextual issue that was raised in the Home's response to the CQC enforcement is the strain in professional relationships between the home and external agencies. The Committee have noted there being an issue with communication as a contextual factor. But as [Witness 1] stated in her evidence: "If there was a strained working relationship between the professionals and home. It doesn't negate the legal responsibility to provide safe care." This was characterised by [Witness 2] as often arising from miscommunication or misunderstanding.

v. The Committee has been furnished with a number of positive references as to the Registrant's good practise (Exhibit 3 pp.20-32), which it should bear in mind in assessing whether the charges found proved are misconduct, however (and bearing in mind the NMC guidance on character references) this evidence has not been tested, is of some age and the objectivity and viewpoint of the authors is difficult to fully assess.

i. The failure in charges found proved constitutes a breach of the Code at paragraphs 1.2; 1.3 (avoid making assumptions in respect of the shared room and door gates); 1.4 (particularly in respect of safeguarding referrals and investigations); 2.2 (capacity assessments and privacy considerations); 3.1 and 3.3; 5.1; 8.2, 8.3, 8.5 (training failures) and 8.6 (safeguarding reports and investigations); 9.4 (training); 10.1 (charge 1c) and 10c)), 10.2 and 14.1, 14.3 (safeguarding), 16 and 19.1."

Submissions on impairment

Mr Hoskins moved on to the issue of impairment and addressed the panel on the need to have regard to protecting the public and the wider public interest. This included the need to declare and maintain proper standards and maintain public confidence in the profession and in the NMC as a regulatory body. This included reference to the case of *Council for Healthcare Regulatory Excellence v (1) Nursing and Midwifery Council* (2) and *Grant* [2011] EWHC 927 (Admin).

Mr Hoskins provided the panel with written submissions:

> *20. If the panel are satisfied of misconduct it will need to address whether this misconduct is remediable. An aspect of this is the extent to which Ms Blore demonstrated (and continues to demonstrate) insight into the identified concerns. Albeit that the Committee have not found Ms Blore to be evasive or obstructive, the evidence of [Witness 1] is at the time of the inspection, this insight was not forthcoming. In her evidence she told the Committee words to the effect of:*
>
> *The key areas that I raised in clinical care were around infection prevention and control, care plans and risk assessments, capacity and consent and medicines and staff recruitment and records. I didn't feel that during the inspection that she took those seriously or agreed with those concerns; and*
>
> *I felt that she didn't take responsibility for instance during the inspection, she would place blame on external agencies rather than accepting responsibilities herself. When I asked for documentation, she said I don't know, it should be there I don't know where it is. Then didn't provide me with anything. I believed they didn't exist.*
>
> *There is further concerns about the attitude of the Registrant at the time of concerns being raised contained in [Witness 1's] statement at §23. Indeed, the Committee have found as part of their findings of fact that they found as "credible and reliable", [Witness 1's] evidence that "Ms Blore was dismissive*

of concerns raised about resident safety and the environment" (p.17 of the facts reasons).

21.Similar concerns are evident in [Witness 2's] evidence in response to [panel] questions:

I think she was very defensive of the allegations as her responses were sometimes. Although she hadn't written the care plans in April, she was flippant with the findings. Well, we all kind of know. Not true because lots of agency staff on an ongoing basis. Couldn't safely say we all knew

Likewise, the Panel have noted that [Witness 1] considered that Ms Blore's response was "at times overly defensive" (p.17 of 67). As such, at the time of the inspections there is clear evidence of lacking insight.

22. In terms of the matters since, the Registrant has obviously not engaged fully in these proceedings, albeit for understandable health reasons. The Committee have seen the home's response to CQC enforcement as part of a process that they are entitled to challenge, the NMC do not submit (given the attribution of the responses cannot be attributed to the Registrant specifically in most cases) that the Home defending itself against enforcement action is indicative of lack of insight on the part of the Registrant. However, the lack of full engagement in the proceedings means that this Committee is not provided with clear or cogent evidence of Ms Blore's current state of insight or the extent to which it has moved on (if at all) from where things sat in early 2022. The most recent evidence perhaps emerges from her response in November 2022 (Registrant's bundle at pp.24-34), which paints a picture of a conspiracy, deflects failings to other organisations and fails to fully appreciate the matters the Committee has now found proved. There is simply no evidence therefore of a cogent recognition of shortcomings in her practise by Ms Blore or a will towards improved practise.

23. In terms of remediation of her practise, the severity and range of the failings was significant for the reasons set out above and ultimately resulted in

the most extensive enforcement action by the CQC. This, rightly, gives rise to the extent to which the failings in the Registrant's practise (given her position of seniority and experience) can truly be regarded as capable of remediation.

24. Even were the Committee to find, however, that the shortcomings were remediable, the Registrant is no longer working as a nurse. For a period of time, she was still employed at the Home, [PRIVATE].

25. The Registrant has provided numerous training certificates, but these are largely mandatory training and date from around the time of the allegations, they therefore fail to demonstrate why this training was not effective at preventing the shortcomings the Committee have now found proved and, additionally, do not demonstrate significant or new learning which has been undertaken since.

26. As such the NMC submit that Ms Blore is impaired based on the first three limbs of the Grant test in the past based on the Committee's findings to date, the severity of misconduct for the reasons set out above. In the future, in light of the state of the Registrant's insight and remediation, there remains an unacceptable future risk also.

27. In addition, the public interest limb of the Grant test is also satisfied in this case based on the severity of the misconduct identified above and the contextual matters therein identified. In short, this is a case of sufficient gravity to also warrant a finding of public-interest based impairment.

Conclusion:

28. In summary, therefore, the extent of facts found proved in this case is serious enough to properly be regarded as misconduct. There is a lack of insight and remediation of this identifiable misconduct which makes a finding of current impairment justified.'

The panel accepted the advice of the legal assessor which included reference to a number of relevant judgments. These included: *Roylance v General Medical Council*, *Nandi v General Medical Council* [2004] EWHC 2317 (Admin), *R (Remedy UK Ltd) v The General Medical Council* [2010] EWHC 1245 (Admin) and *Cohen v GMC* [2008] EWHC 581 (Admin).

Decision and reasons on misconduct

When determining whether the facts found proved amount to misconduct, the panel had regard to the terms of the Code.

The panel was of the view that Ms Blore's actions did fall significantly short of the standards expected of a registered nurse, and that Ms Blore's actions amounted to a breach of the Code. Specifically:

> ***'1 Treat people as individuals and uphold their dignity***
> *1.2 make sure you deliver the fundamentals of care effectively*
> *1.3 avoid making assumptions and recognise diversity and individual choice*
> *1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay'*
>
> ***'2 Listen to people and respond to their preferences and concerns***
> *2.1 work in partnership with people to make sure you*
> *deliver care effectively*
> *2.2 recognise and respect the contribution that people can make to their own health and wellbeing'*
>
> ***'3 Make sure that people's physical, social and psychological needs are assessed and responded to***
> *3.1 pay special attention to promoting wellbeing, preventing ill health and meeting the changing health and care needs of people during all life stages*
> *3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life*

3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care'

'5 Respect people's right to privacy and confidentiality
As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.
5.1 respect a person's right to privacy in all aspects of their care'

'8 Work co-operatively
8.2 maintain effective communication with colleagues
8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
8.5 work with colleagues to preserve the safety of those receiving care
8.6 share information to identify and reduce risk'

'9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues
9.4 support students' and colleagues' learning to help them develop their professional competence and confidence'

'10 Keep clear and accurate records relevant to your practice This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.
10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need'

'14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm
14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly'

'16 Act without delay if you believe that there is a risk to patient safety or public protection
16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so'

'19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice
19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
19.3 keep to and promote recommended practice in relation to controlling and preventing infection'

'20 Uphold the reputation of your profession at all times
20.1 keep to and uphold the standards and values set out in the Code'

'25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system
25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is

maintained and improved, putting the needs of those receiving care or services first
25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken'

The panel appreciated that breaches of the Code do not automatically result in a finding of misconduct. However, the panel carefully considered Ms Blore's professional background and level of responsibility. She qualified as a nurse in 2000 and held managerial roles between 2011 and 2014, before becoming the Registered Manager in 2014. In this position, she combined both clinical leadership and the statutory responsibilities of a registered manager. Given her significant experience and seniority, the panel determined that there was therefore a reasonable basis for clear and expectations that she would exercise effective leadership, management and oversight of professional nursing standards, and thereby ensuring safe and compliant care within the Home.

The panel identified multiple and serious clinical and operational failings on Ms Blore's part. While it acknowledged that an inspection by the CQC on a single day might reveal failures that individually could be viewed together, they represented failures that amounted to breaches of the Code. Moreover, the sheer breadth of failures was found to be persistent and cumulative and made matters far more serious at the home in terms of increasing the risk of harm to vulnerable and frail residents. The fact that these were not confined to a single point in time but spanned a period extending beyond the inspection itself exacerbated the risks at the Home. This demonstrated systemic weaknesses in leadership and governance and have contributed significantly to increasing both the seriousness and scope of the misconduct.

The panel was conscious of the wider context of the COVID-19 pandemic and accepted that this period placed unprecedented pressure on health and social care services, including nursing homes. However, it noted that the inspection took place towards the latter stages of the pandemic, by which time substantial guidance had

been issued and learning had been widely implemented across the health and care sectors. As the Registered Manager and clinical lead, Ms Blore had full responsibility for ensuring that such guidance was embedded in the Home, particularly in relation to infection control, the use of PPE, staff training, and the maintenance of safe and effective care plans. However, it noted that this was not the case.

In considering the evidence, the panel noted that approximately 9 of the 20 residents in the Home were affected by the identified failings. The concerns were wide-ranging including: safeguarding, infection control, record keeping, and staff training. These themes were reflected in the charges found proved. For example, in relation to record keeping (Charge 1(b)) it found that Ms Blore had failed to ensure that risk assessments for a resident were completed in accordance with established care plan policies, representing a fundamental lapse in basic nursing practice.

This was especially so in the case of Resident 2 who was admitted to the Home on 6 January 2022. It found that according to the Home's own policy, an initial care plan assessment should have been produced by 13 January 2022.

The panel heard from Witness 1 who clarified the CQC's regulatory function in scrutinising the delivery of fundamental nursing care, following the Health and Social Care Act 2008 and reinforced the expectation that nurses must maintain core elements of care delivery, including proper care planning.

The panel also considered evidence in relation to Resident 2 and noted that it contained documents such as eating, drinking and nutrition care plan, personal care plan, body temperature plan, mobility, moving and handling, a sleeping care plan and a death and dying care plan. All these documents were dated either 27 or 28 January 2022; dates falling outside the requirements of the Home's care plan policy.

Significant concerns were also identified in relation to infection control (Charges 4(a), 4(b), 4(c), 4(d)(i), 4(d)(ii), 4(f), and 4(h)) and incomplete training records and inadequate training (Charges 6(a)–(d)) - all of which were found proved. These failings demonstrated inadequate implementation of essential infection prevention measures. Ms Blore's failures placed service users at risk of infection due to poor

infection control and a failure to comply with national COVID-19 guidance. Ms Blore did not provide an account or an explanation to the panel in this regard. The failings in relation to the use of face masks were multiple and wide-ranging. The panel also acknowledged that considerable learning had taken place in relation to infection control practices since the start of the COVID-19 outbreak in early 2020, and standards of PPE had improved over time however, Ms Blore has been found to fail in leading her staff by example and failing to provide training for them. In essence her actions have contributed significantly to the increase likelihood of risks from infections spreading through the Home.

The panel had regard to the concerns which they found to be substantiated in relation to Charges 8(a) and 8(b) and included a failure to appropriately investigate an incident regarding a resident's safety. It is again a matter of significant concern to the panel that Ms Blore, knowing that Resident 4's personal documentation included assessments identifying that he didn't use mobility aids, mobilised using furniture, and had been assessed in relation to continence, sitting and standing ability, and walking, had no corresponding care plan in place addressing the risks had been identified. There were also shortcomings in Ms Blore's report about the incident, where the panel found no evidence of any investigation and/or safeguarding referral.

On this basis, and with the number of charges it found proved, the panel concluded that the nature, extent, and persistence of these failings across multiple fundamental areas of care, clearly demonstrate serious departures from expected professional standards.

The panel therefore found that Ms Blore's actions did fall seriously short of the conduct and standards expected of a nurse and amounted to misconduct.

Decision and reasons on impairment

The panel next went on to decide if as a result of the misconduct, Ms Blore's fitness to practise is currently impaired.

In coming to its decision, the panel had regard to the NMC Guidance on 'Impairment' (Reference: DMA-1 Last Updated:28/01/2026) in which the following is stated:

> *'Being fit to practise is not defined in our legislation but for us it means that a professional on our register can practise as a nurse midwife or nursing associate safely and effectively without restriction.'*

Nurses occupy a position of privilege and trust in society and are expected at all times to be professional and to maintain professional boundaries. Patients and their families must be able to trust nurses with their lives and the lives of their loved ones. To justify that trust, nurses must be honest and open and act with integrity. They must make sure that their conduct at all times justifies both their patients' and the public's trust in the profession.

In this regard the panel considered the judgment of Mrs Justice Cox in the case of CHRE v NMC and Grant in reaching its decision. In paragraph 74, she said:

> *'In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.'*

In paragraph 76, Mrs Justice Cox referred to Dame Janet Smith's "test" which reads as follows:

> *'Do our findings of fact in respect of the doctor's misconduct, deficient professional performance, adverse health, conviction, caution or determination show that his/her/ fitness to practise is impaired in the sense that S/He:*

a) has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm; and/or

b) has in the past brought and/or is liable in the future to bring the medical profession into disrepute; and/or

c) has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the medical profession; and/or

d) …'

The panel had regard to the principles set out in *Cohen v General Medical Council* [2008] EWHC 581 (Admin) when considering whether the concerns were capable of remediation and whether they were highly unlikely to be repeated.

In Ms Blore's case, the panel noted that she had previously practised as a nurse without any regulatory concerns and had an otherwise unblemished career. It also took into account the positive testimonials provided, which spoke to her prior professionalism and commitment. Ms Blore's GP colleague stated:

> *'Carolyn is a very experienced, confident, competent and insightful nurse with more than her fair share of common sense. She demonstrated detailed knowledge of the patients in her care and made accurate assessments of their needs.'*

A co-worker of Ms Blore said:

> *'Carolyn is able to take responsibility for a group of clients, adhere to their needs, assess and monitor their safety, make safe changes to their care plans and report to the multi-disciplinary team involved in their care.'*

The panel took into account the training certificates provided by Ms Blore. The panel noted that these certificates covered a range of training from 2019 to the end of April 2022. However, these are of limited value because they relate largely to mandatory requirements and do not address the underlying regulatory concerns that gave rise to the charges that were subsequently found proved.

The panel further acknowledged the exceptional circumstances of the COVID-19 pandemic and the significant pressures placed on the wider health and social care system. It accepted that the nursing Home was not immune from these pressures and that, as the Registered Manager, Ms Blore faced difficult decisions, including responding to urgent admissions from distressed families. The panel recognised that these circumstances may explain, to some extent, why at times, she departed from established policies and regulatory requirements. It also noted evidence suggesting that some of the difficulties were compounded by strained working relationships with external agencies, including the local authority and the Clinical Commissioning Group (CCG).

However, while these factors provided important context and mitigation, the panel was not persuaded that they outweighed the seriousness and breadth of the failings identified under Ms Blore's leadership at the home.

The panel first considered whether any of the limbs of the Grant test were engaged in the past. The panel determined that Ms Blore's misconduct placed patients at risk of harm. It also determined that Ms Blore's misconduct constituted a serious breach of fundamental tenets of the nursing profession because she had failed to prioritise people, practise effectively, preserve safety and promote professionalism and trust. The panel decided that Ms Blore failed to uphold the standards and values of the nursing profession, thereby bringing the reputation of the nursing profession into disrepute.

The panel therefore concluded that's limbs a, b and c of the Grant test are engaged in respect of Ms Blore's past conduct.

The panel next considered whether the limbs of the Grant test are engaged in the future. In this respect, it considered the case of Cohen in which the court addressed the issue of impairment with regards to the following three considerations:

a. Is the conduct that led to the charge easily remediable?
b. Has it in fact been remedied?
c. Is it highly unlikely to be repeated?

The panel also set out of the facts set out in the NMC Guidance of insight of strengthening practice (FTP-15).

The panel first considered whether Ms Blore's conduct is capable of being addressed it determined that Ms Blore misconduct could be addressed had she engaged. However, the panel found that there was no material before it to show what, if anything, she had done to remediate her conduct and strengthen her practice. In the absence of such evidence, it could not conclude that she is now safe to practice unrestricted.

The panel would wish to note in mitigation, that Ms Blore's ill health may have prevented her from participating in these hearings. This could have enabled her to provide insightful reflection, evidence of strengthened nursing practice and an updated record of her training in the areas of regulatory concern.

Regarding insight, the panel considered whether Ms Blore had demonstrated an adequate understanding of her misconduct and its consequences. The panel found that there has been insufficient reflection on her part. In particular, Ms Blore had not demonstrated a clear understanding of how her actions and omissions placed vulnerable residents at risk of harm. In addition, she had not shown meaningful engagement given the seriousness of the concerns identified.

The panel further noted that there was a lack of evidence to demonstrate that Ms Blore had taken steps to address or manage the risks identified at the time of the CQC inspection. While the panel acknowledged that her health circumstances may have affected her ability to engage fully with the process.

The panel is of the view that Ms Blore has not demonstrated that she recognised what went wrong, accepted responsibility for her failings, or identified what she would do differently in the future. As such, the panel concluded that there remains a real risk of repetition if she were permitted to return to practice without restriction. The panel therefore decided that a finding of current impairment is necessary on the ground of public protection.

The panel also considered the wider public interest. Given the breadth and seriousness of the failings, and the fact that they involved vulnerable residents in a care setting, the panel determined that public confidence in the profession would be undermined if a finding of impairment was not made. Fellow professionals would regard the misconduct as serious and expect restriction to be placed on her ability to practice as a registered professional. Accordingly, the panel concluded that Ms Blore's fitness to practise is currently impaired on both public protection and public interest grounds.

The panel bore in mind that the overarching objectives of the NMC; to protect, promote and maintain the health, safety, and well-being of the public and patients, and to uphold and protect the wider public interest. This includes promoting and maintaining public confidence in the nursing and midwifery professions and upholding the proper professional standards for members of those professions.

The panel determined that a finding of impairment on public interest grounds is required because of the serious and wide-ranging nature of the concerns identified in this case. The misconduct involved multiple fundamental areas of care which occurred in a setting involving highly vulnerable residents. In light of the spectrum of failings, the panel concluded that public confidence in the profession and the regulatory process would be undermined if a finding of impairment were not made.

The panel further considered that fellow professionals would regard the conduct as deplorable, particularly given Ms Blore's senior position as both clinical lead and Registered Manager, where a high standard of leadership and accountability was expected. The panel determined that it is necessary to uphold proper professional standards and maintain trust in the nursing profession by ensuring that Ms Blore is not permitted to practise without restriction. Accordingly, a finding of impairment on public interest grounds is required.

Having regard to all of the above, the panel was satisfied that Ms Blore's fitness to practise is currently impaired.

Sanction

The panel has considered this case very carefully and decided to make a striking-off order. It directs the registrar to strike Ms Blore off the register. The effect of this order is that the NMC register will show that Ms Blore has been struck off the register.

In reaching this decision, the panel has had regard to all the evidence that has been adduced in this case and to the NMC Guidance on *'The sanctions available'* (Reference: SAN-2 Last Updated: 28/01/2026).

The panel accepted the advice of the legal assessor.

Submissions on sanction

Mr Hoskins made submissions on sanction.

Mr Hoskins submitted that a striking-off order is the most appropriate and proportionate sanction in this case. He submitted that, in accordance with the SAN-1, the function of any sanction is not to punish the registrant, but to protect the public, to promote and maintain public confidence in the profession, and to uphold proper professional standards.

Mr Hoskins submitted that there are substantial aggravating factors which significantly increase the gravity of Ms Blore's misconduct. He relied on the authority of *Mitchell v Nursing and Midwifery Council* [2025] EWHC 1496 (Admin), in particular paragraph 47, which confirms that it is entirely proper for a panel to treat matters underpinning a finding of misconduct as aggravating features where they increase the seriousness of the conduct. He submitted that certain matters that form part of misconduct do not prevent the panel from giving them additional weight when assessing overall seriousness. In this case, he submitted that the panel had clearly identified the relevant issues and would be entitled to regard them as increasing the seriousness of the misconduct.

Mr Hoskins submitted that the misconduct was not an isolated incident but formed part of a pattern of behaviour over a period of time, which demonstrates sustained failings in professional practice. He emphasised that there is also a marked absence of insight on Ms Blore's part, and that this makes it difficult to conclude that the concerns have been addressed or that the risk of repetition has been reduced. He further submitted that the misconduct involved vulnerable individuals receiving care, thereby heightening the seriousness of the case. Although there may not have been evidence of actual harm, he submitted that Ms Blore's actions created a risk of significant harm, which is a matter for serious regulatory concern. He also submitted that there was a failure to work collaboratively with colleagues, and that Ms Blore had the ability to decline admissions or raise concerns where communication was inadequate but failed to do so.

In addressing mitigation, Mr Hoskins submitted that there are limited factors which the panel may take into account. He referred to the context of the COVID-19 pandemic, where practitioners were working under considerable strain. However, he submitted that this does not excuse the misconduct, particularly given the stringent guidance that was put in place during that time. He also submitted that working relations were strained which may have contributed to the misconduct. Furthermore, he submitted that the Home owner was not clinically trained and the home itself was up for sale, which may suggest a lack of adequate clinical support in the workplace. Nonetheless, he submitted that these mitigating factors carry limited weight when balanced against the seriousness, and nature of the misconduct, as well as the absence of insight and remediation.

Mr Hoskins submitted that taking no further action would be wholly inappropriate in this case, as the Sanctions Guidance (SG) makes clear that such an outcome is exceptional and requires careful justification. Given the seriousness of the findings, this could not properly be justified. Similarly, he further submitted that a caution order would also be insufficient, as such an order is only appropriate where there is a low risk of repetition and the concerns are limited in nature.

In relation to a condition of practice order, Mr Hoskins submitted that this sanction is also inappropriate. While such an order may be suitable where there are no deep-

seated attitudinal concerns and where the issues are capable of remediation, he submitted that there are serious doubts as to whether Ms Blore is able or willing to remediate. He highlighted that there is no evidence of remediation despite the passage of time, and that Ms Blore has not meaningfully engaged with the process, including indicating that her health issues would prevent her from fully participating. He further submitted that there is no clear indication that she intends to return to practice or comply with any conditions that might be imposed. In addition, the misconduct is wide-ranging in nature, making it difficult to formulate conditions that would be sufficiently specific, measurable, and workable. In those circumstances, he submitted that conditions of practice order would not be effective in protecting the public.

Mr Hoskins submitted that a suspension order may be appropriate where the misconduct is serious but not fundamentally incompatible with continued registration, and where there is a realistic prospect of the registrant addressing the concerns and returning to safe practice. However, he submitted that these criteria have not been met. He submitted that there is no evidence of insight or remediation, and no indication that Ms Blore intends to return to practice or take steps to address the concerns. He therefore submitted that a suspension order would therefore fail to meet the statutory objectives, as it would neither adequately protect the public nor maintain public confidence in the profession.

Finally, Mr Hoskins submitted that a striking off order is both necessary and proportionate in this case, in accordance with SAN-2E of the SG. He submitted that the scale and breadth of the misconduct, when considered alongside the sustained absence of insight and lack of remediation over a prolonged period, render striking off the appropriate sanction. In those circumstances, he submitted that only a striking off order would adequately protect the public, maintain public confidence in the profession, and uphold proper professional standards, and is therefore the appropriate and proportionate outcome in this case.

The panel accepted the advice from the legal assessor.

Decision and reasons on sanction

Having found Ms Blore's fitness to practise currently impaired, the panel went on to consider what sanction, if any, it should impose. The panel has borne in mind that any sanction imposed must be appropriate and proportionate and, although not intended to be punitive in its effect, may have such consequences. The decision on which sanction to apply is a matter for the panel independently exercising its own judgement.

The panel took into account the following aggravating features:

- The misconduct occurred over a sustained and prolonged period of time.
- There was a significant absence of insight. Ms Blore has failed to demonstrate understanding of her failings, both at the time of the CQC inspection and subsequently.
- The misconduct involved particularly vulnerable residents, all of whom were elderly, frail, and living with multiple diagnoses.
- Ms Blore's actions and omissions created clear risks of harm to those in her care.
- Ms Blore held a senior position as Registered Manager and Clinical Lead, placing her in a position of trust with clear professional and leadership responsibilities.
- At the time of the CQC inspection, national guidance on managing COVID-19 and infection control within healthcare settings was well-developed and clearly communicated; however, Ms Blore failed to respond appropriately to that guidance.

The panel also took into account the following mitigating features:

- Ms Blore had a long and unblemished career, with no prior referrals to the regulator.
- The events took place during the COVID-19 pandemic, a period which placed significant and unprecedented strain on healthcare settings, particularly care homes.

- [PRIVATE].

The panel first considered whether to take no action but concluded that this would be inappropriate in view of the seriousness of the case as the SG makes clear that such an outcome is exceptional and required clear justification. The panel decided that it would not protect the public, leaves open the risk of repetition and was inappropriate. It is therefore not in the public interest to take no further action.

The panel next considered a caution order and had regard to the NMC Guidance on *'Caution order'* (Reference: SAN-2b Last Updated: 28/01/2026) in which the following is stated:

> *'A caution is only appropriate if the Committee has decided there's no risk to the public or to people using services that requires the professional's practice to be restricted. This means the case is at the lower end of the spectrum of impaired fitness to practise, but the Committee wants to mark that what happened was unacceptable and must not happen again.'*

The panel considered that Ms Blore's actions were not at the lower end of the spectrum and found that there is a continuing risk to patient and public safety. Whilst the panel recognised that the issues are capable of remediation, it had no evidence as to whether Ms Blore was able or willing to remediate. This has been the case from the outset and throughout the proceedings. On this basis a caution order would also be inappropriate, as such an order is only sufficient where there is a low risk of repetition and the concerns are limited in nature. The panel therefore determined that a sanction that does not restrict Ms Blore's practise would not protect the public. The panel also determined that it would be neither proportionate nor in the public interest to impose a caution order.

The panel next considered whether to place a condition of practice on Ms Blore's registration. In considering whether conditions of practice are appropriate, the panel had regard to the factors set out in the NMC Guidance on 'Conditions of practice order' (Reference: SAN-2c Last Updated: 28/01/2026).

The panel concluded that whilst workable conditions could be created to address the failings found proved in this case, the absence of a clear indication that Ms Blore intends to return to practice or comply with any conditions means that imposing a condition of practice order would not be appropriate in this case. For conditions to work they need to be achievable for Ms Blore. That is to say, she would need to be in a healthcare setting under stringent supervision arrangements that could be monitored and enforced.

The panel noted that in an email received from Ms Blore dated 17 November 2022 she said the following:

> *"…If you look on the registration you will see that I am now not registered with the NMC I couldn't get a job anywhere with the sanctions that they have put on me as a nurse. I knew that if I started work I would have to inform you but as I haven't contacted you it's because I am not working in the health profession and you will no longer have to keep me on your books or contact me in anyway."*

In light of this email and Ms Blore's continuing disengagement with the process the panel could not persuaded that Ms Blore would be in a position to comply with any conditions. It considered whether she would be able to secure suitable employment and engage with the requirements of a conditions of practice order, particularly given her current health and lack of engagement. The panel also noted the NMC's correspondence with Ms Blore in which she described herself as *'retired'* and confirmed that she is not currently working, which further raised concerns about the practicality and effectiveness of conditions.

The panel went on to consider whether a suspension order is appropriate in this case. The panel had regard to the NMC Guidance on *'Suspension order'* (Reference: SAN-2d Last Updated: 28/01/2026) in which the following factors on when a suspension order may be appropriate are set out:

- *'the impairment is very serious but not fundamentally incompatible with continuing to be a registered professional*

- *an outcome less severe than strike-off would still satisfy the over-arching objective.'*

The panel also had regard to the key considerations as set out in the NMC Guidance to take into account before imposing a suspension. It noted the following list of factors that may make a suspension order an appropriate sanction:

- *'the charges found proved are at the most serious end of the spectrum and call into question the professional's suitability to continue practising, either currently or at all*
- *while it is possible that the professional could be fit to practise in future, only a period out of practice would be sufficient to allow them to fully strengthen their practice through reflection, the development of their professional skills and / or development of insight and remediation*
- *there is a risk to the safety of people using services if the professional were allowed to continue to practise even with conditions*
- *what went wrong is so serious that public confidence in the profession and professional standards could not be maintained if the professional were able to continue practising without stopping for a period of time*
- *despite the seriousness of what happened, the professional has engaged in the proceedings and has shown at least some meaningful insight which evidences a realistic possibility that they will continue to develop this insight, address their concerns and return to practice.'*

Whilst the panel acknowledged that the risks identified could be managed by temporarily removing Ms Blore from the Register, it considered that it would not be sufficient to uphold public confidence in the profession and maintain professional standards due to the seriousness of the misconduct and the wide-ranging nature of the charges found proved. Given Ms Blore's lack of engagement, limited insight, failure to provide an up-to-date record of training and development, the panel considered that there is no realistic possibility that she would address the concerns to such a level where she could return to practise safely.

The panel noted that suspension is intended to be a temporary measure, allowing a registrant the opportunity to address concerns and demonstrate that they are fit and able to return to safe practice. However, the panel was not satisfied that this had any prospects of being achieved in Ms Blore's case because she would need to demonstrate insight, remediation, and a willingness to engage with the regulatory process. Her ongoing health difficulties, coupled with her limited engagement and lack of evidence of remediation, led the panel to conclude that a suspension order would not serve the purpose for which it is intended.

In reaching its decision, the panel carefully considered the balance between suspension and striking off, taking into account the principles of proportionality and fairness, as set out in SAN-3 and SAN-2E of the SG. Ultimately, it concluded that a suspension order would not adequately protect the public or maintain confidence in the profession. The panel therefore determined that a suspension order would not be a sufficient, appropriate or proportionate sanction.

In considering a striking-off order, the panel had regard to the NMC Guidance on *'Sanctions for the highest risk cases'* (Reference SAN-4 Last Updated: 28/01/2026).

The panel determined that a striking-off order is the most appropriate and proportionate sanction in this case. It placed weight on a number of factors including the absence of any meaningful insight or reflection from Ms Blore, both at the time of the misconduct and in the intervening period.

The panel had regard to the following considerations as set out in the NMC Guidance entitled *'Striking-off order'* (Reference: SAN-2e Last Updated; 28/01/2026):

- *Do the charges found proved raise fundamental questions about their professionalism?*
- *Can public confidence in the profession be maintained if the professional is not removed from the Register?*
- *Is there any amount of insight and reflection which could keep people receiving care and members of the public safe, maintain public confidence in the profession, and uphold professional standards?*

- *Is there a realistic prospect that, after suspension, the professional will have gained insight and strengthened their practice such that the risk they pose will have reduced?*

The panel has concluded that there are serious questions about Ms Blore’s professionalism in this case. It has decided this due to the seriousness and breadth of the failings, together with the complete absence of insight and remediation. In these circumstances there is no realistic prospect that Ms Blore would be willing to develop the necessary insight and strengthening of her practice to a level that would sufficiently reduce the risk she poses. This means a lesser sanction would not be appropriate or proportionate.

The panel concluded that only a striking-off order would adequately protect the public, maintain public confidence in the profession, and uphold proper professional standards.

Ms Blore’s actions were significant departures from the standards expected of a registered nurse and are fundamentally incompatible with her remaining on the register. The panel was of the view that the findings in this particular case demonstrate that Ms Blore’s actions were serious enough, that to allow her to continue practising would not protect the public and would undermine public confidence in the profession and in the NMC as a regulatory body.

Balancing all of these factors and after taking into account all the evidence before it during this case, the panel determined that the appropriate and proportionate sanction is that of a striking-off order. Having regard to the effect of Ms Blore’s actions in bringing the profession into disrepute by adversely affecting the public’s view of how a registered nurse should conduct herself, the panel has concluded that nothing short of a striking-off order would be sufficient in this case.

The panel considered that this order was necessary to mark the importance of maintaining public confidence in the profession, and to send to the public and the profession a clear message about the standard of behaviour required of a registered nurse.

This will be confirmed to Ms Blore in writing.

Interim order

As the striking-off order cannot take effect until the end of the 28-day appeal period, the panel has considered whether an interim order is required in the specific circumstances of this case. It may only make an interim order if it is satisfied that it is necessary for the protection of the public, is otherwise in the public interest or in Ms Blore's own interests until the striking-off sanction takes effect. The panel heard and accepted the advice of the legal assessor.

Submissions on interim order

The panel took account of the submissions made by Mr Hoskins. He submitted that an interim suspension order (ISO) for 18 months is the most appropriate interim order on the grounds of both public protection and the wider public interest. He submitted that there remains an ongoing risk to the public, as identified in both the impairment decision and the sanction decision.

Mr Hoskins submitted that in relation to public protection, the risk identified has not been sufficiently mitigated and continues to be present. He submitted that an ISO is also required in the public interest. As the findings in the case amount to a serious breach of professional standards.

Decision and reasons on interim order

The panel was aware that its decision to impose an interim order is not automatic but concluded that it was appropriate and necessary in this case.

The panel carefully considered whether the imposition of an ISO was appropriate in these circumstances. It noted that Ms Blore is not currently practising in a clinical role, is experiencing poor health, and has indicated that she has retired from nursing. In light of these factors, the panel recognised that an interim order might not be

appropriate in this case. However, the panel was satisfied that an interim order is necessary for the protection of the public and is otherwise in the public interest. Having reviewed it decisions carefully it then concluded that the test an interim order was met in this case.

The panel concluded that an interim condition of practice order would not be appropriate or proportionate in this case, due to the reasons already identified in the panel's determination for imposing a striking-off order. The panel therefore imposed an interim suspension order for a period of 18 months.

If no appeal is made, then the interim suspension order will be replaced by the striking off order 28 days after Ms Blore is sent the decision of this hearing in writing.

That concludes this determination.